| 7.0°. | be executed |
|------------------------------|---|
| tal Records, P.O. Box 68760, | i; The law requires that the death certificate be execute |
| ecords, P. | aw requires that th |
| n of Vital Re | g Physician; The la |
| Ē | Ing F |

| | | For State Registrar | State of Ma | arylan | | epartment of H Certificate of D | | | giene Reg. No | 009 | 09001 |
|--|-------------------|---|--|------------------------------------|---------------|--|--------------------------------|------------------------------|--------------------------|---|---|
| | | Decedent's Name (First, Middle) | , Last) | | | | | 2. Date of De | ath | | 3. Time of Death |
| Physicia /Modio | | | Robert | T | | Wellbrock | | March | Day | Year 200 9 | 23:50 PM |
| /Medic | | 4a. Facility Name (If not institution | | <u> </u> | | 4b. City, Town, or | | | 1 | County of Deat | h |
| A. C. | | Sinai Hospita | 1 of Baltim | ore | | Baltim | ore | | | N/A | |
| Funeral | | 5. Social Security Number | | e (In yrs. I | | nday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th | 9. Birt | hplace (State or Foreign untry) |
| Director | | 214-30-6222 | 1 ₹ M 2 □ F | 74 | Υ | rs. | | Sept. | 1, 19 | 34 Ne | w York |
| w w | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town | or Location | | | | | 10d. Inside City Limits |
| f sho | ō | | | | | | | | | | 1 □ Yes 2 □ No |
| the N | Director | Maryland Balt 10e. Street and Number | imore | | Pike | esville | | | 10a. Citiz | en of What Co | 21 |
| with Sa or | | | 1. T | | | | 208 | | | U.S.A. | |
| ms 2 | Funeral | 7610 Seven Mi | 12. Was Decedent | Ever in U.S | S. | 13. Was Decedent of His If Yes, specify Cubar | | ecify Yes or No | - 1 | 4. Race - Ame | rican Indian, |
| ifter o | | 1 ☐ Never Married 2 ☑ Marri | Armed Forces? ed 1 √2 Yes 2 □ I | No | | | | Rican, etc.) | | Black, White | e, etc. |
| al", o | þ | 3 ☐ Widowed 4 ☐ Divorced | ed 1 Tyes 2 1 If Yes, Give 1 Year or Dates: | 953–19 | 957 | 1 □ Yes 2 No | Specify: | | | Specify: | White |
| filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar mat be notfined at | Completed | 15. Decedent (Specify only highes | 's Education | | 16a. | Decedent's Usual Occupa | ition uring most of work | ina | 16b. Kin | d of Business/ | Industry |
| thin se. | npl | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | (Give kind of work done d life. DO NOT use retired) | | 9 | · | _ | |
| led w lygier her th | S | | 11 | | | Systems Ana | | /F24 1 F-1-#- | | . Gover | nment |
| be fil | Be | 17. Father's Name (First, Middle, | _ | | | | 18. Mother's Name | | | _ | G 4.C. |
| 2 should be and Mental is marked c | ဥ | Harvey | | We | $\overline{}$ | cock | | <u>Ethel</u> | M | ======================================= | Swift |
| d 2 st th an 7 is r traur | | 19a. Informant's Name/Relationsh | | | | Mailing Address (Street a | | | | | |
| 1 and Health em 27 | | Patricia W 20a. Method of Disposition | ellbrock Wi | ife 20h. Pi | | 510 Seven Mi | | P1Kes | | , Mary 1 | |
| Pages nent of int: If It | | 1 ☑ Burial 2 ☐ Cremation | 3 Removal from State | 1 | | Disposition (Name of crematory or other place | i i | | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mast be notified at once. | | 4 Donation 5 Other (Si 21. Signal You From all Stryica) | | Dru | id F | Ridge Cemete 22. Name and Addres | | | | | Maryland |
| Depi Impo any | | Tank to | Hoan | | _ | 1050 York | 1/1 | lowson, | son F Mary | uneral land 2 | Home, Inc. 21204 |
| | | 23a. Part 1. Enter the disease, or shock, or heart failure. List | complications that caused only one cause on each li | d the death ne. | . Do n | ot enter the mode of dying | g, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | · Pulno | nevu | . 0 | m bolism | | | | | Onset and Death |
| /Medical Examiner | | resulting in death) | Due to (or as | | | | | | | | |
| | L. | Sequentially list conditions, | b. Adeno | | | | Albert Scott | | | | 3 WILL |
| led sit | nine | dany, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequ | lente o | 7- | J | | | | |
| The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Examiner | that initiated events resulting in death) Last | c Due to (or as | a consequ | ience o | (): | | | | | |
| e be siciar | | | | | | | | | | | |
| ificate g physi | edical | | d | | | | | | - 1 | | |
| eath certif attending for use as | M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | | 2 | 3d. Date of del | livery |
| deatl | Physician/M | in the past 12 months? 1 □ Yes 2 □ No | 1 Live birth 4 Pregnant a | | | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | | | Month | Day Year |
| t the by th | hys | 9 ☐ Unknown | 9 □ Unknown | | | | | | | | |
| res tha signed be det | by F | Part II. Other significant condition | ns contributing to death b | ut not resu | ılting in | the underlying cause give | n in Part I. | 23e. Did t | obacco us | se contribute to | the cause of death? |
| w require been si should b | led | Coronary ar | tery disc | asc | | | | 1 🔼 | Yes 2 |]No 3 ☐ Pr | robably 4 Unknown |
| law r as be 2 sh | Completed | Emphysema | <u> </u> | | | | | 24a. Was | | 24b. Were au | topsy findings available completion of cause of |
| | E C | Cor Balmona | (0 | | | | | perfo | rmed? 2. No | death? | 2 □ No |
| sician; The law s certificate has l irector, page 2 s | Be (| 25. Was case referred to medical examiner? | | | | | 26. Place of Deat | | | | |
| Physic this of | | 1 Yes 2 No | Hospital: 1 💢 Inpatie | ent 2 🗌 | ER/Out | patient 3 DOA Othe | r: 4 🗆 Nursing Ho | ome 5 ☐ Resi | dence 6 | ☐Other (Spe | cify) |
| Attending Physician; r death. ector: After this certifici by the funeral director, p | :uo | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Inju (Month, Da | ıry ıy, Year) | 28b. Ti In | jury Work | | 28d. Describe | how injury | occurred | |
| tend leath tor: / | cati | 2 Accident investig | ation | | | | /es 2□No | | | | |
| or Ai after of Direct in by | Certification: To | 4 ☐ Homicide determi | | ury - At no c. <i>(Specif</i> y | me, rari | m, street, factory, office | | City or To | Street and wn, State) | d Number or Hi | ural Route Number, |
| To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | ical C | (Check only 2 Medical | g Physician: To the best Examiner: On the basis of | of examinat | | | | | | | |
| thin 2 the 1 the 1 | Medical | one) 29b. Signature and title of certifier | and manner st | ated. | | 29c. License | | | | e signed (Mont | |
| 5 × 5 0 | _ | - | M·D | | | RES | | | | ch 19 | |
| , , | } | | | | | | | | - 1201 | -11 1) | |
| 124 | | 30. Name and address of person Jeena Sandelf | who completed cause of c | leath (Item | 23a) (| Paltimore ? | 16.14 CON | redere | Ave ? | Baltimo | re MD-21215 |
| Sta | te | 31. Date fled Worth, Bay Year | 32. Registr | ar's 6ignat | ture | Date I I was a factor | 1 | | 1 | | |
| Registra | ar | MAR 2 3 2009 | 32. Registr | B. 19 | Far | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #10e Per State of Maryland Department of Health and Mental Hygiene 09002 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Wallace Μ. 7:45 DM Michael 18th 2009 larch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallscows.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1.6 70 Baltimore Season's Hospice Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1**⊠** M 2□ F 216-90-5888 38 Jamáica Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Nes 2 No MD NΔ 10e. 2506 and Number 10f. Zip Code 10g. Citizen of What Country? 21215 Jamaica 2916 Grantley Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ※☐No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes A If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married þ 1 ☐Yes 2 ▼No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Mechanic Auto Shops 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Callan Norman Wallace 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 Grantley Ave, Baltimore, Md 21215 Norman Wallace-Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 3/30/09 Baltimore, Maryland Metro Crematory 4 Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death END STAGE CARDIOMYOFATIYY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ALCOHOLIC LIVEN DISEASE Physician/Medical Examiner Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown

Physician /Medical Examiner

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It Medical Examples in that by matter descriptions.

Je filed with.

*al Hygiene.

*er than "pr

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed physician and the burial-transi attending pl signed by the a icate has been siç ; page 2 should b director, this After this funeral d

Be

Certification: To

Medical

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending

death.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hepatic Encephalopathy

25. Was case referred to medical 1 Yes 2 No

6 Could not be

determined

Hospital: 28b. Time of 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

24a. Was an autopsy performed? 2 No

1 □ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified

27. Manner of Death

1 Natural

3 ☐ Suicide

4 Homicide

2 ☐ Accident

29c. License number 145931

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 SMITH AVE Suite 203 Baltimore MD 21209 Ve brah I

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ROY ALVIN 0:34 WILSON MARCH 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 213-38-5459 **Director** 66 Feb. 11,1943 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Rocky Ridge 10f. Zip Code -28a-f MD Frederick 10g. Citizen of What Country? 10e. Street and Number or items 23a or 13424-D Old Frederick Rd. U.S.A. 21778 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: à White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) laborer construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond C. Wilson Ruth L. Eckard ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Pages 1 and 2 s ment of Health ar Rachel M. Wilson - wife 13424-D Old Frederick Rd., Rocky Ridge MD 21778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Typ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 3/24/2009 Keysville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St., Woodsboro, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NON **Physician** SMALL /Medical Due to (or as a consequence of): Examiner TOBACLO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine siclan and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, signed by the attending physiclan I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ CHF COPA 2 No 3 Probably 4 Unknown CAD, 1 Tes HTN, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □ Yes 2 2 100 of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4√0 1 Depatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. e Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 2-1

State Registrar

31. Date filed (Month, Day, Year)

aca

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W. 7th St., Frederick, MD 21701 32. Registrar's Signature MAR 2 3 2009

D66166

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 March Xiu Ou Yang /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2312 Chetwood Circle #101 Baltimore Timonium If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 M 2 □ F 56 1953 Director 212-07-6979 March 13. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 1∩a State 10b County 28a-f show ral", or items 23a or 28a-f shor Funeral Director Baltimore Timonium Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2312 Chetwood Circle #101 China 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Chinese Completed by 3 Widowed 4 Divorced Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natur any injury or other traumatic event, the Modical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nail Salon Technician 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lin Yue Jiao ၉ Ou Yang Quan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2312 Chetwood Circle #101 Timonium, Md. 21093 Yanghong Ou Yang/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 3-23-09 Towson, Md. 4 ☐ Donation 15 ☐ Other (Specify) Hilltop Service Co. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Ligensee 1050 York Rd. Towson, Md. 21093 23a. Part 1. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) usece S2 **Physician** teriosc and lovescular /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform performed? 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

and manner stated.

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8:34

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☑ No

China

a

State Registrar

completely filled in within 24 hours a To the Funeral D

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

09-02148 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Dylan Kenneth Yukna 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 16, 2009 1550 hrs Medical Examiner Dylan Yukna 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21629 Donnell Jones Road Tilghman Talbot If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 32 Director May 10, 1976 Country) Maryland 1X M 2 F 219-08-4995 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show d at once. 1 Yes 2 X No Talbot Tilghman MD with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21629 Donnell Jones Road 21671 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. 1 Never Married 2 Married Armed Forces? Yes 2 X No White and 2 should be filed within 72 hours after theith and Mental Hygiene. item 27 is marked other than "natural", or traumatic event, the Medical Examiner n If Yes, Give Yea Yes 2 X No specify: Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fishing/Crabbing Waterman MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sheila Yukna Leary Be Bernard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8620 Park Dr., Chestertown, MD Sheila Giersch-mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, Burial 2 X Cremation 3 Removal from State Hilltop Serv Corp Pages 03/19/09 Towson, MD 22. Name and Address of Facility Fulleral nome the 21. Signature of Pe 1050 York Rd., Towson, MD 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Intraoral Gunshot Wound Immediate Cause (Final disease **kaminer** or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? O Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. σ. Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 this 1 V Yes No After 28a. Date of Injury (Month, Day Year) Mar 16, 2009 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: Subject shot self 1535 hrs Natural Yes 2 V No Pending death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 21629 Donnell Jones Road, Tilghman, MD (Specify) Single Family determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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O.C.M.E

111 Penn Street, Baltimore, MD 21201

March 17, 2009

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 March 17, **Physician** Helen Doris Zimmerman 0.00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Frederick Villa Nursing Home Catonsville 8. Date of Birth (Month, Day, Year) Feb. 4, 1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1□ M 2√ F Maryland 90 218-05-6556 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10d. Inside City Limits if than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 526 South Longwood Street United States Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Saleswoman Retail Unknown permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Talley Morris Rebecca Crawford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 562 South Longwood Street, Baltimore, MD 21223 Dennis L. Zimmerman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Rurial 2 Cremation 3 Removal from State Loudon Park Cemetery: 3-23-2009 Baltimore, Maryland 5 ☐ Other (Specify) 4 □ Danation 22. Name and Address of Facility Ambrose Funeral Home, Inc. Fungeal Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** ATHEROSCLE ROTIC CARDIOVASCULAR EARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner District for as a consequence off g physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 □Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and fittle of certifier asanthalamano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21228 M. VASANTHA KUMAN 516. N. 32. Registrar's Signature 31. Date filed (Month, Day, Year) NAR 2 3 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hyman Bader March

Year 4:20 pM 07 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harmony Hall Retirement Community Columbia Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Months Days Hours Min 80 Yrs Director 081-20-8699 November 21,1928 New York Usual Residence of Decedent ath with the Maryland 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits 23a or 28a-f show Director 1 ☐Yes 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 Funeral 15115 Interlachen Drive, #710 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. r than "naturai", or ite the Medical Examiner Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify 2 Specify 3

Widowed 4

Divorced WWII Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Personal Finance other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of ပ Abraham Bader Bertha Goldman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a David Bader - Son other 6421 Enchanted Solitude Place, Columbia, Maryland 21044 ortant: If item ? Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 03/09/2009 Olney, Maryland 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease shock, or heart failure. I complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DINOMUSING disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine lanan and burial-tran the death certificate be execu resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the the attending photose as the IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐ No certificate has trector, page 2 sl 24a. Was an autopsy Vascular de 20 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Specify) After this 5 ☐ Residence funeral frer death. 27 Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours uneral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) Ň To the lewithin 2. and manner stated 29b. Signature and title of certifie 121

State Registrar 1. Date filed (Month, Day,

Columbia hy

39 Name and address of person who completed cause of death (Item 23a) (Type, Print) Pelseca Elon MD 6334 Codov

Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Clydia Blankner 2:52 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10438 Brighton Rd. Ocean City Worcester 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year 8/23/1914 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ XF 94 217-14-5966 Director MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 10438 Brighton Rd. 21842 USA Funeral Was Deced Armed Forces? Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. l be filed within 72 hours after on that Hygiene "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No ò Specify. Specify: 3 X Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 should be filed with and Mental Hygier 7 is marked other th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde D. Brown 2 Emily T. Younger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun once. June Yoncha / daughter 10438 Brighton Rd., Ocean City, MD 21842 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 Removal from State Cape Henlopen Crem. 3/6/2009 4 Donation 5 Other (Specify) Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications a shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardiomyopatt disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 mon for Month Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2/2 No 1 ☐ Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SE Residence 6 Other (Specify) 1 Yes > No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural To the Hospita ... within 24 hours after death.

To the Funeral Director: After a filed in by the fur 5 Pending investigation M 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title of ca 29d. Date signed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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ed (Month, Day, Year)

Exaster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** March Philip 6:00a Jose Briscoe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's 9414 Cheltenham Avenue Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, Sept. 16, 1958 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 1 M 2 □ F Washington 219 76 0684 50 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Yes 2 No Director Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 US 9414 Cheltenham Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🌠 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 □Yes 2 🗖 If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 □Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doris Holt George Phillip Briscoe ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9414 Cheltenham Avenue Clinton, MD 20735 19a. Informant's Name/Relationship (Type. Print) 9414 Cheltenham Avenue Clinton, MD Brenda Briscoe/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens 3/11/09 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility MODELL BRISCOE-TONIC FUNERAL HOME PA 2294 Old Washington Rd Waldorf, MD 20601 23a. Paryli. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final MALIGNANT NEOPLASM, OROPHARYNX disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 XXatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed and burial-trar P.O. Box 68760, attending physician for use as the buria signed by the a d be detached for Division of Vital Records, cate has been signal, page 2 should b certificate

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is fine first in the most carry than at

the Maryland

death with

1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other traumatic event

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Completed Be Certification: To 3 Suicide 4 🗌 Homicide

Medical

29a. Certifier

(Check only one)

To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p

State Registrar

and manner stated. 29b. Signature and title of pertifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 9 2009

6 Could not be

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State Registrar 31. Date filed (Month, Day, Year)

ORIGINIAL

32. Registrar's Signature

| | | 1 | For State Registrar | . 100 | State | of Marylar | | artmen rtificate | | | ınd M | | jiene | 009 | 09011 | |
|---------------------|---|----------------|--|------------------------------|--|--|---|-----------------------------------|---------------------|---------------------|-------------|--|-----------|------------------------------|---|---------|
| | Physicia /Medic | an | 1. Decedent's Name Dorothy | e (First, Middle | e, Last) | | Black | | - | | | 2. Date of Dea Month March | 4, Day | | 3. Time of Death 11:50 A M | |
| | Examin | | 4a. Facility Name (I | | n, give street and n n Nursing | Home | | Fort | Wash | Location o | on | | Pr | county of Death | orges | |
| | Funeral Director | | 5. Social Security N 577-32-2: Usual Residence of | 239 | 6. Sex 1 ☐ M 23€ F | 7. Age (In yrs. 83 | | If Under Months | Days | If Under a | Min. | 8. Date of Birth (Month, Day 11/10/1 | 925 | Esmo | nplace (State or Foreign unity) ont, Virgin | ia — |
| | filed within 72 hours after death with the Maryland Hygiene. Whysiene. Wher then "neturel", or Items 23a or 28e-1 show after then "neturel", or Items 23a or 28e-1 show ant, the Mydical Examinar must be notified at | | 10a. State MD | 10b. County Prince | e Georges | | ty.Town or Lo rt Wash | ningto | | | | | IOG Citic | zen of What Co | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No | |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or flems 23a or 28e-1 show any injury or other treumetic event. The Medical Examiner must be notified at Once. | ral DI | 10e. Street and Nu 3008 Ra | | 12. Was De | ocedent Ever in U | J.S. 13. | | 0744 | spanic Orig | gin? (Spe | cify Yes or No- | U | SA 4. Race - Ame | rican Indian, | _ |
| 9600 | nours after oural; or Iter | by | 1 ☐ Never Marr 3 🖾 Widowed | 4 Divorced | ried 1 Tes If Yes, 0 Year or | Forces? 2 No Give Dates: | | 1 🗆 Yes | 2 <mark>₩</mark> No | Specify: | | | | Specify: B | lack | |
| Maryland 21215-0036 | d within 72 h jiene. r then "neti | Completed | (Special Special Speci | cify only highe | t's Education st grade completed College | (1-4or 5+) | 16a. Dece (Give life. | kind of wo DO NOT us Sale | | | t of workii | ng | | vate | | |
| yland ; | ould be filed Mental Hyg arked othe etic event, | To Be C | 17. Father's Name Edward | | Last) | | | | | Eli | za N | (First, Middle, elson | | | | |
| | t and 2 sho fealth and im 27 is ma her treume | | 19a. Informant's N Marian R 20a. Method of Dis | . Swin | hip (Type, Print) gler/ Nie | | 3008 | Ramsg | gate | P1., | Fort | / Route Numbe : Washir | ngton | | 0744 | _ |
| Baltimore, | iit. Pages artment of Hortent: If ite injury or of | | | ☐ Cremation 5 ☐ Other (S | | m State Ar | Place of Dispo cemetery, cre lingto | matory or on on Nat 2. Name ar | iona | 1 Cem | | 1/09 | Arli | ngton, | Virginia ineral Home | _ |
| Ba | permi Depa Impo any ii | | 23a, Part1, Enter | the disease, or | complications tha | t caused the dea | th. Do not en | 16 Ke | nned | y St. | NW, | Washin | gtor | | 20011 Approximate Interval Between | |
| | Pnysician /Medical Examiner | er | Immediate Cause disease or condition resulting in death) Sequentially list or if any leading to it cause. Enter Und | (Final on | a | to (or as a conse | quence of): | a y | 1- | art 14p | fert | en se | | | Onset and Death | |
| 8760, | cate be executed oblysician and the burial-transit | dical Examiner | cause. Enter Und Cause (Disease that initiated seen tresulting in death) | r injury s | c | to (or as a conse | | | | | | | | | | _ |
| .O. Box 68 | that the death certifica ed by the attending ph detached for use as th | Physician/Med | IF FEMALE: 23b. Was deceded in the past 12 1 Yes 2 | 2 months? | 1 ☐ Liv | outcome of pregree birth 2 Petersegnant at time of known | al death 3 | □Ectopic p □ Other <i>(s)</i> | | | | | 2 | 23d. Date of del Month | ivery Day Year | |
| rds, P | sign d be | by | Part II. Other sign | ificant conditi | ons contributing to | death but not re | sulting in the t | underlying (| ause giv | en in Part I | | 23e. Did to | 7. | | the cause of death? | |
| Vital Records, | | Completed | | | | | | | | _ | | | | 24b. Were au prior to death? | utopsy findings available completion of cause of | ' |
| /ita | Physicien: The this certificate ral director, pag | Be | 25. Was case refe examiner? | erred to medica | Hospital: | | | | Oth | | | (Check only o | | | | |
| of | Physi this o | To | | No. | 11 | | ER/Outpatie | | | A-C. INI | - | me 5 Resid | | | cify) | _ |
| Division o | tending leath. tor: After the fune | Certification: | 27. Manner of Dea 1 Natural 2 Accident 3 Suicide | 5 Pendi invest 6 Could | igation not be | te of Injury ionth, Day Year) ace of Injury - At | 28b. Time of Injury | М | | yat k? Yes 2□ | No | 28d. Describe h | | | ural Route Number, | _ |
| Div | To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the | | 4 Homicide | 1 Certifyi | na Physician: To | ilding, etc. (Spec | cify) nowledge, dea | th occurred | at the tir | ne, date ar | nd place, | City or Tov | cause(s) | and manner as | s stated. | |
| | To the Howithin 24 h | Medical | (Check only one) 29b. Signature an | | | e basis of examinanner stated. | nation and/or i | 29 | c. Licens | e number | | | 29d. Dat | te signed (Mont | th, Day, Year) | _ |
| | 8 | | 30. Name and add | | who completed co | ause of death (Ite | эт 23а) (Туре | o, Print) | 1 | 192 | 955 | ton, | 1. | 1.1 | 2009 | |
| 2 | St | ate | 31. Date filed (Mo | | | 2. Registrar's Sign | | | | 200 | - L | ton, | 10 | ia, | | |
| • | Regist | rar | MAR (| 9 2009 | Deneura | A. 19. 19 | park | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:15 A M 3 2009 <u>Fannie H. Bucci</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Timonium Stella Maris If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 □ M 2 🔀 F MĎ 12-5-1910 98 219-28-6452 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 9214 Furrow Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: White If Yes, Give Year or Dates: 3 □ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Hame Homemaker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carmella Lascula Frank Liberto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2204 Pleasant Dr., Catonsville, MD 21228 Alfred F. Bucci / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 【★Burial 2 ☐ Cremation 3 Removal from State 3-10-2009 Marriottsville, MD Crest Lawn Mem. Gdns. 5 ☐ Other (Spec)(y) 4 ☐ Donation 22. Name and Address of Facility Harry H. Witzke's Family FH, INC 21. Signatur of Juneral Se M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.

1 and 2 should be filed within Health and Mental Hygiene.

Pages 1

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

MARCH

/Medical

Director

Funeral

<u>Ş</u>

Be Completed

ပ

MD

the attending physician and hed for use as the burial-trar signed by the a

the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

FANNIE BUCCI

Examiner by Physician/Medical completely filled in by the funeral director, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be

Completed

Certification: To

Medical

29b. Signature and title of certifie

JACKIE JONES,

| shock, or heart failure. List only | one cause on each line. | | Onset and Death |
|--|---|--|--|
| Immediate Cause (Final disease or condition | a CONGESTIVE HEART FAILURE | | |
| resulting in death) | Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b | | |
| cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | CDue to (or as a consequence of): | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} = 2\frac{1}{M} \) No 9 \(\text{Unknown} \) | 23c. If yes, outcome of pregnancy 1 | 23d. Date of Month | delivery Day Year |
| Part II. Other significant conditions | contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribu 1 ☐ Yes 2 No 3 ☐ | te to the cause of death? Probably 4 Unknown |
| | | autopsy prior performed? deat | e autopsy findings available to completion of cause of h? Yes 2 □ No |
| 25. Was case referred to medical | 26. Place of Death | (Check only one) | |
| examiner? 1 ☐ Yes 2 X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho | me 5 Residence 6 X Other (| Specify) HOSPICE |
| 27. Manner of Death 1 | (Month, Day, Year) Injury Work? on M 1 □ Yes 2 □ No | 28d. Describe how injury occurred | |
| 3 Suicide 6 Could not to determined | | 28f. Location (Street and Number of City or Town, State) | or Rural Route Number, |
| 29a. Certifier 1 Certifying P | hysician: To the best of my knowledge, death occurred at the time, date and place, iminer: On the basis of examination and/or investigation, in my opinion, death occurred and magner stated. | and due to the cause(s) and mann red at the time, date and place, and | er as stated. due to the cause(s) |

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

100

2300. DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

CRNP

| | | | lease | | | | | indelible ini | | - | | • | | |
|---|----------------|---|------------------------------|------------------------------|------------------------|-------------|-------------------|--|---------------------|-------------------------------|------------------|------------------------------|------------------|---------------------|
| | | For State | | State | ı ıvıaı | ryiani | | partment of Certificate of | | ivientai Hy | • | 0000 | 0.00 | 0013 |
| | | Registrar 1. Decedent's Name (First, | Middle, La | ist) | | | | er lincale or | Dealii | 2. Date of De | Reg. No | 200: | | e of Death |
| Physici | | Maurice | | | Ρ. | | | Dwittino | hom | Month | Day | 2009 Yea | | 0 |
| /Medio | | 4a. Facility Name (If not ins | stitution, giv | | | | | Britting 4b. City, Town, | or Location of Dea | March | | County of De | | |
|) — | | VA MARYLAND | Satt 1 | Ith Care | Su | sten | 2 | P D | oint | | 1 | 1 ecil | | |
| Funeral | | 5. Social Security Number | 6. 5 | | | (In yrs. la | | ay) If Under Year | If Under 24 Hrs | | rth av. Year) | 9. B | irthplace (St | ate or Foreign |
| Director | | 217-28-2654 Usual Residence of Deced | | I KAJIVI ZLI F | | 77_ | Yrs | | | 1-20-1 | 932 | | aryĺan | d |
| land ow | | 10a. State 10b. C | | | | 10c. City, | Town o | Location | | | | | 10d. Insid | e City Limits |
| Mary I-f she | ģ | MD Wi | comic | 0 | | Dox | con | sburg | | | | | 1 🗆 | res 2√∏No |
| h the | Director | 10e. Street and Number | COMITC | 0 | | _rai | SOIIS | 10f. Zip Code | | | 10g. Citi | zen of What (| Country? | |
| be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Mydical Examirur must be notified at | | 7396 Parson | sburg | Road | | | | 21 | 849 | | USA | Δ | | |
| r dea | Funeral | 11. Marital Status | | 12. Was Dece Armed Fo | rces? | | . 1 | Was Decedent of If Yes, specify Cul | Hispanic Origin? (S | Specify Yes or No | | 14. Race - An Black, Wh | nerican India | ٦, |
| s afte | by Fu | 1 Never Married 2 | | 1 X Yes If Yes, Gi | 2 □ No ve | 195 | 50- | 1 ∐Yes 2 No | | , | | Specify: W | | |
| hour tural' | | 3 X Widowed 4 ☐ Div | orcea cedent's Ea | Year or D | ates: | 195 | | ecedent's Usual Occu | Ingtion | | | | | |
| in 72 n "na n dic | Completed | (Specify only | highest gra | ade completed) | | 1/1 | (G | ive kind of work done e. DO NOT use retire | durina most of wo | erking | I OD. KII | nd of Busines | s/maustry | |
| d with giene rr tha | E O | Elementary/Secondary (0 |)-12) | College (1 | -4or 5+) | ' | We | 11 Drille | r | | Owr | ı Busir | iess | |
| al Hy l othe | Bec | 17. Father's Name (First, N | liddle, Last, |) | | | | | 18. Mother's Na | me (First, Middle | , Maiden | Surname) | | |
| Ment Ment arked arked | ၉ | George | | | | Brit | ting | ham | Α. | Blanch | e | Jao | ckson | |
| 2 sho n and is m raum | | 19a. Informant's Name/Re | | | | | 19b. M | ailing Address (Stree | t and Number or R | ural Route Numb | er, City or | Town, State | , Zip Code) | |
| l and Health | | Wendy Shock | ley - | Daught | er | | 101 | 3 Hunting | ton Drive | | | | | |
| iges int of h | | 20a. Method of Disposition 1 | | | State | 1 | | sposition (Name of crematory or other pla | | Date | 20c. Lo | cation - City o | er Town, State | • |
| perr it. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once. | | 4 □ Donation 5 □ Ot | | | | Wice | mic | Memorial | | -2009 | Sali | sbury, | Maryl | and |
| perin Dep Imp any i | | 21. Signature of Funeral Si | ervice Licer | see | 7 b | | | 22. Name and Addr | . 1 | Bounds F | | | | |
| | | 23a. Part. Enter the disea | ISE OF CO. | olications that o | aused th | ne death | Do not | 705 E. Ma | in St. Sa | llisbury | , Mar | yland | 21804 Approxi | mate . |
| Dhysisian | | shock, or heart failure Immediate Cause (Final | . List only | me cause on e | ach line. | | | | ing, odon do cardia | o or respiratory a | | | Interval | Between nd Death |
| Physician /Medical | | disease or condition resulting in death) | | a. Due to | | conseque | | CNIA | | | | | UNKD | OWD |
| Examiner | | | | buo to | 01 40 4 1 | ooriocque | .1100 01). | | | | | | 1 | |
| B + | Je l | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | J | Due to | or as a | conseque | ence of): | | | | | - 22 | | |
| ecute ind transi | Examiner | that initiated events | | c | | | | | | | | | | |
| be executed ician and burlal-transit | | resulting in death) Last | | Due to (| or as a c | conseque | ence of): | | | | | | | |
| cate physic | dical | | | d | | | | | | | | | | |
| eath certificate be executed attending physician and for use as the burial-transit | Physician/Med | IF FEMALE: | | 23c. If yes, out | come of | nregnan | cv | | | | | | | |
| atter for u | cian | 23b. Was decedent pregna in the past 12 months | | 1 ☐ Live t | oirth 2 | Fetal | death | 3 ☐ Ectopic pregnan 5 ☐ Other (specify) _ | су | | 2 | 3d. Date of d Month | elivery Day | Year |
| the c | hysi | 1 □Yes 2 □ No 9 □ Unknown | | 9 ☐ Unkn | | | | | | | | | | |
| w requires that the dispension by the should be detached | | Part II. Other significant co | onditions c | ontributing to de | ath but | not result | ing in the | underlying cause gi | ven in Part I. | 23e. Did t | obacco us | se contribute | to the cause | of death? |
| en siç | ed | Cerebrovesci | clar 1 | Acciden | t; [|)!Spi | etes | Mellitus | · Type II | 10 | Yes 2□ |]No 3∏ F | Probably 4 | Unknown |
| law re as be 2 sho | pet | Hypertension | HERT | ing Los | 25 | | | | 1, | 24a. Was | | | utopsy findir | |
| The ate h | Completed by | , | ' | 9 | | | | | | auto perfo | rmed? | prior to death? 1 □ Ye | | of cause of |
| cian: ertific | Be | 25. Was case referred to m examiner? | edical | | | | | | 26. Place of Dea | ath (Check only o | | 1216 | 3 2 pg/110 | |
| physic this c | ၉ | 1 ☐ Yes 2 No | | | | | | ilent 3 1 DOA | | lome 5 ☐ Resi | dence 6 | □Other (Sp | ecify) | |
| Ilng F | Certification: | | ending | | of Injury h, Day, Y | | 8b. Time Injur | y Wo | rk? | 28d. Describe | now injury | occurred | | |
| death death stor: / the | cat | 3 ☐ Suicide 6 ☐ C | nvestigation could not be | | of Injury | At hom | o form | M 1 C |]Yes 2□No | 006 | | ,,, | | |
| after after Direction by | erii | 4 ☐ Homicide | etermined | | | (Specify) | ie, iaiiii, | street, lactory, office | | 28f. Location (City or To | vn, State) | Number or F | turai Houte N | umber, |
| splta nours neral y filled | | 29a. Certifier 1 🔀 Ce | rtifying Ph | ysician: To the | best of i | my knowl | edge, de | eath occurred at the t | ime, date and place | e, and due to the | cause(s) | and manner | as stated. | |
| To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the | Medical | (Check only 2 Me | dical Exan | niner: On the ba and manr | asis of e | xaminatio | on and/o | investigation, in my | opinion, death occu | urred at the time, | date and | place, and du | e to the caus | e(s) |
| Vithi To th | Ž | 29b. Signature and title of c | ertifier (| | | | | 29c. Licens | se number | | 29d. Date | signed (Mon | th, Day, Yea |) |
| 11/1/ | | Mulier | 10 | auto | / , ! | 1. | ٥. | 1510 | 1-490 | | 9 | -3- | 09 | |
| 1xx | | 30. Name and address of po | | completed caus | e of deat | th (Item 2 | | e, Print) | | . ~ | (| | / | |
| | | MELECIA SAN 31. Date filed (Month, Day, | 140S, | M.D. | AN | 1210 | 1/3N | d Healtho | epe sys | ten, PE | rry | roint. | MD | 21902 |
| Stat Registra | | MAR (| | | gistrars | Signatu | 1 | all | | | , | | | |
| | | MARI | D ZU | A COM | | 10 | 7 | 57.7° | | | | | | |

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Dorothy Μ. Bradley PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 544564K REGIONAL MEDICAL TENINSULA Viconica If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 K F Hours 83 Director 216-16-7666 10/04/1925 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Wicomico Maryland Salisbury Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21804 Truitt Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. 1 □ Never Married 2 □ Married 1 ∐Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. þ Specify: white 3 XWidowed 4 □ Divorced Year or Dates "natural" Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Ite Me any Injury or other traumatic event, Ite Me once. College (1-4or 5+) Elementary/Secondary (0-12) Mardelva News 12 bookkeeper 17. Father's Name (First, Middle, Last)

Maxwell J. Moore 18. Mother's Name (First, Middle, Maiden Surname)
Lula Hill ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Bradley/son 1512 Stone Post Ct., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place of Springhill Memory 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/7/09 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) <u>Gardens</u> 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 no Hal 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumonina luk disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t autopsy perform certificate 1 ∐Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one, Hospital. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours after users...

To the Funeral Director: After the further than the further investigation 1 Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) E. Charroll ST Saluby MS 21801 10 100 00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Division of Vital Records,

1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

EDWARD WILLIAM BOWEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLINGTON DR. LA PLATA, MD. 20646 20c. Location - City or Town, State MD.VETERANS CEMETERY 3-12-09CHELTENHAM, MD. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 Approximate Interval Between Onset and Death To the Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation neral Director: A 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 03-03.00 $\gamma(A)$ 2005986 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juinth No CIKMBOGA 7503 CARLOS 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

FEB.28

,2009

3. Time of Death

22:58

GEORGES

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐Yes 2 No

WASH., D.C.

Specify: WHITE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 5:00 ам Arthur Edward Blank March 01 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Director 91 September 26,1917 399-03-8815 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "redical Examiner must be notified at Director 1 ☐Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Priscilla Drive 20904 death v U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evanthe and. 1 ☑Yes 2 ☐ No If Yes, Give 1 Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify \$ Specify: 3 Widowed 4 Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Supervisor National Security Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Fred Blank Helen Kreutz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine J. Blank - Wife 1800 Priscilla Drive, Silver Spring, Maryland 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 □ Donation 5 🖾 Other (Specify) Entombment Catholic Cemetery Mausoleum 03/16/2009 La Crosse, Wisconsin 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc.) C 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final **Physician** Sepsis /Medical resulting in death) Due to (or as a consequence of): Examiner Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Atrial Fibrillation Due to (or as a consequence of): Box 68760. Physician/Medical Pneumonia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 □No 1 □Yes 2 🛚 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after dec. 1 X Natural 5 ☐ Pending investigation 2 Accident 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Medical 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2
To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D60826 March 1, 2009 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) Ksharma Garg, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State of Maryland / Department of State of Maryland / Department / Dep | artment of Health and IV <i>rtificate of Death</i> | nental Hygle/ Reg. | 2000 | 1 19117 |
|---------------------------------|---|-------------------|--|--|---|-------------------------------|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | imodio or Bodin | 2. Date of Death | | 3. Time of Death |
| | Physicia /Medic | | Jadean Colgan Bishop | | Feb. 27, | Day Year 2009 | 8:00 A M |
| The Control of | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Deat | h |
| | | | 2 Lawrence Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Annapolis If Under 1 Year If Under 24 Hrs. | 9 Date of Birth | Anne Aru | |
| | Funeral Director | | 1 □ M 2 K F 57 Vrs | Months Days Hours Min. | 8. Date of Birth (Month, Day, Ye March 3, | 1951 New | hplace (State or Foreign untry) York |
| | ס | | 102-40-4917 Usual Residence of Decedent | | march 5, | 1931 New | |
| | irylan show | _ | 10a. State 10b. County 10c. City, Town or Lo | | | | 10d. Inside City Limits 1 ☐ Yes 2 1 No |
| | Ba-f s | Director | Maryland Anne Arundel Edgewater | | 40- | Oiting of Miles On | ** |
| | with th | ij | 10e. Street and Number 361 Southport Drive | 10f. Zip Code 21037 | 109. | . Citizen of What Co USA | untr y ? |
| | ns 23 | Funeral | | Was Decedent of Hispanic Origin? (Sp If Yes, specity Cuban, Mexican, Puerto | ecify Yes or No- | 14. Race - Ame | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudical Examiner must be notified at once. | by Fui | 1 Never Married 2 1 Married 1 TYes 2 No | If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes Ž ☐ No Specify: | Hican, etc.) | Black, White | |
| Baltimore, Maryland 21215-0036 | 2 hour | | 15 Decedent's Education 16a, Dece | dent's Usual Occupation | 166 | b. Kind of Business/ | Industry |
| 215 | hin 7% | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | kind of work done during most of work DO NOT use retired) | ing | | |
| 7 | ygien ygien her th | Cou | 3 Hom | emaker | (PT - 1 A 8 4 4 4 - 1 8 - 1 | Home | |
| and | be fill ntal H ed oth | Be | 17. Father's Name (First, Middle, Last) John J. Colgan | Anna Bu | e (First, Middle, Mai oke | gen Surname) | |
| ž | should be and Mental marked o | ဥ | | ng Address (Street and Number or Ru | | itv or Town. State. I | Zip Code) |
| <u>≅</u> | and 2 s ealth ar n 27 is ner trau | | | outhport Drive, Ed | | - | |
| Jre, | of Hei | | 20a. Method of Disposition 20b. Place of Dispo | osition (Name of matory or other place) | Date 200 | c. Location - City or | Town, State |
| Ĕ | Pages ment of ant: If ite ury or o | | 4 □ Donation 5 □ Other (Specify) Our Lady | of Sorrows Cem. 3/4 | 4/2009 We | est River | ,Maryland |
| 3a∏ | permit. Departr Importa any Inju | | | 2. Name and Address of Facility Geo | | | |
| | 20 = 40 O | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en | 973 Solomons Islan | | | Approximate |
| | | S 6 | shock, or heart failure. List only one cause on each line. | Acres and | or respiratory arrest. | ' | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) Due to (or as a consequence of): | cancer | | | Tys. 9 mos. |
| | Examiner | | | | | | |
| | ed sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Uniteritying Cause (Disease or injury | | | : | |
| - | ifficate be executed g physician and as the burial-transit | xan | resulting in death) Last C | | | | |
| 68760, | se be (| edical E | d. | | | | |
| | ng ph | | IE ECMALE. | | | | |
| Box | leath certific attending p | ian/I | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ | Ectopic pregnancy | | 23d. Date of del Month | livery Day Year |
| o o | he de | Physician/M | in the past 12 months? 1 | Other (specify) | | | • |
| σ, | w requires that the de been signed by the should be detached | y Ph | Part II. Other significant conditions contributing to death but not resulting in the u | inderlying cause given in Part I. | 23e. Did tobac | co use contribute to | the cause of death? |
| rds | quires en sigi uld be | ed by | | | 1/A Yes | 2 No 3 P | robably 4 🗆 Unknown |
| 900 | e law re has bee | Completed | | | 24a. Was an autopsy | 24b. Were au | utopsy findings available completion of cause of |
| <u> </u> | The sate h | Com | | | performed | d? death? | 2 □No |
| Vita | ician: sertific ector, | Be (| 25. Was case referred to medical examiner? Hospital: Hospital: | 26. Place of Dea | th (Check only one) | S | ister's |
| o | Physician: The la r this certificate har ral director, page 2 | : To | 1 ☐ Yes 2 No | | ome 5 ☐ Residenc | | Home |
| o | rding Ph th. : After thi e funeral | ition | 1 Natural 5 □ Pending (Month, Ďay, Year) Injury 2 □ Accident investigation | of 28c. Injury at Work? M 1 Yes 2 No | | .,, | |
| Division of Vital Records, P.O. | To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a | Certification: To | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) | reet, factory, office | 28f. Location (Stree City or Town, S | et and Number or Ru State) | ural Route Number, |
| | ours a | | 29a. Certifier 1.K Certifying Physician: To the best of my knowledge, dear | th occurred at the time, date and place | , and due to the caus | se(s) and manner a | s stated. |
| | To the Hospital within 24 hours a To the Funeral I completely filled | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. | nvestigation, in my opinion, death occu | rred at the time, date | and place, and due | e to the cause(s) |
| | Within To the Comp | Ž | 29b. Signature and title of certifier | 29c. License number | | . Date signed (Mont | |
| | Calo. | | Delonule W | 019838 | 2 | 2/27/2 | 004 |
| | 500 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | | | 1 0-1 | |
| | Sta | te | 24 Data filed (Month Day Your) 22 Begintrar's Signature | gate Rd., Annapol | ıs, Maryla | and 21401 | |
| | Registr | | MAR 05 2009 Discus S. | arked | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9

| | | | For State Registrar | State of | Marylan | | artment c rtificate d | | | | giene (Reg. No. | 2009 | 0901 | 8 |
|-------------------------------|--|----------------|---|--|------------------------|-------------------------|---|----------------------------------|-------------|---------------------------------|---------------------|---|--|--------|
| | Dhyoisi | 20 | 1. Decedent's Name (First, Middle | | | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death | |
| | Physici /Medio | | Harold R. Bass | | | | | | | Februa | ry 27 | , 2009 | 5:40 A | VI |
| | Examin | er | 4a. Facility Name (If not institution | | nber) | | | n, or Location | of Death | | | County of Death | | |
| | Francis | | 2824 Fenne1 Ro | | 7. Age (In yrs. | last hirthday) | Edge If Under 1 Ye | ewater | r 24 Hrs. 1 | 8. Date of Bir | | ne Arur | ndeL place (State or Fore | an |
| | Funeral Director | | 577-52-7980 | 1∭ M 2□F | 70 | Yrs. | Months Da | ays Hours | Min. | (Month, Da 4/30/ | y, Year) | Cou | intry) ginia | gii |
| | pu , | | Usual Residence of Decedent | | | | | - | | -+/ 30/ | | | | |
| | shov shov | 'n | 10a. State 10b. County Maryland Anne | Arundel | 10c. Cit | ty, Town or Lo Edgew | | | | | | | 10d. Inside City Limi 1 □Yes 2][] N | |
| | the M 28a-f notifie | Director | 10e. Street and Number | mr under | | | 10f. Zip Coo | de | | | 10a Citiza | en of What Cou | | |
| | 3a or | ٥ | 2824 Fennel Rd | ł | | | | 21037 | | | rog. Onizi | USA | ing: | |
| | death ms 2 r mus | Funeral | 11. Marital Status | 12. Was Deced | dent Ever in U. | S. 13. | | | rigin? (Spe | ecify Yes or No Rican, etc.) | - 14 | 4. Race - Ameri | | |
| 90 | after or ite | y Fu | 1 ☐ Never Married 2 ☐ Marr | If Van Cive | 2 □ No | | i res, specily (I⊡Yes 2∭1 | | | rican, etc.) | | Black, White, | etc. | |
| Ö | hours ural", | d by | 3 ☐ Widowed 4 ☐ Divorced | Year or Da | tes: 1955- | -59 | | | | | | | White | |
| 5 | n 72 l "nat | Completed | 15. Decedent (Specify only highes | st grade completed) | | (Give | dent's Usual Oo kind of work do DO NOT use re | one durina mos | st of worki | ng | 16b. Kind | d of Business/Ir | ndustry | |
| 212 | y withigiene. | mo | Elementary/Secondary (0-12) 12th | College (1- | 4or 5+) | | re Mana | | | | Hea | ting an | d A/C | |
| b | e filec al Hyg I othe vent, | BeC | 17. Father's Name (First, Middle, | Last) | | | | | er's Name | (First, Middle, | | | | |
| ylaı | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Wedfeal Examiner must be notified at | 10 | Ear | nest Bass | | | | I | da Ma | e Walle | er | | | |
| Jar | 2 sho | | 19a. Informant's Name/Relationsl | | | 1 | | | | | | Town, State, Zi | p Code) | |
| e, | 1 and Health em 27 ther t | | Dianne M. Bass 20a. Method of Disposition | / Wife | 20h E | | | | | ater, l | | 037 ation - City or To | C4-4- | |
| nor | Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snit: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at | | 1 M Burial 2 ☐ Cremation | 3 Removal from S | tate | | sition (Name o natory or other | : | | | | • | | |
| altimore, Maryland 21215-0036 | permit. Pag Department Important: I any Injury o | | 4 □ Donation 5 □ Other (S) | | ן אט | vetera | ns Cem | etery ddress of Facili | 3/4/1 | 09 | Crov | vnsville | e, MD al Home | _ |
| ñ | permit. Departr Imports any Inju | | Matt like | le | | 2 | 973 Sol | omons | Islan | orge r. id Rd. 1 | ылыл Таты | ater, M | ai nome | |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that ca | used the deat | | | | | | | | Approximate Interval Between | |
| Profession of the Parket | Physician | | Immediate Cause (Final disease or condition | Rona | Q C00 | 0-00 | rano | m | | | | | Onset and Death | |
| | /Medical Examiner | | resulting in death) | Due to (c | r as a conseq | | - / - / | | | | | | | |
| | LXaIIIIICI | <u>.</u> | Sequentially list conditions, | b | or as a conse | uonos afi: | | | | | | | | |
| | uted I nsit | Examiner | Sequentially list conditions, if any, issuing simple cause. Enter Underlying Cause (Disease or injury | oue to to | r as a conseq | denise on | | | | | | | | |
| Ĵ. | exection and items in and items in a tra | Exa | that initiated events resulting in death) Last | c Due to (o | r as a consequ | uence of): | | | | | | | | - |
| 8760, | The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit | dical | | d | | | | | | | | | | |
| 9 | ertifice ing ph | Med | IF FEMALE: | | | | | | | | | | - 1 | |
| Box | leath certific attending p | ian/ | 23b. Was decedent pregnant in the past 12 months? | | rth 2 Feta | Ideath 3□ | Ectopic pregn | | | | 23 | 3d. Date of deliv | ery Day Year | |
| o | the de | Physician/Me | 1 □Yes 2 □No 9 □ Unknown | 4 ☐ Pregna 9 ☐ Unkno | ant at time of d wn | leath 5∟ | Other (specify | y) | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Day Tour | |
| ت. ت. | w requires that the diben signed by the should be detached | | Part II. Other significant condition | ns contributing to dea | ath but not resu | ulting in the ur | derlying cause | given in Part I | l. | 23e. Did to | obacco use | e contribute to t | he cause of death? | |
| Vital Records, | quires en sigi uld be | ed by | | | | | | | | 1 🗆 Y | 'es 2□ | No 3 ☐ Pro | bably 4 ☐ Unknow | 'n |
| ဝ္ပ | as bee | Completed | | | | | | | | 24a. Was | | | opsy findings availab | |
| Ť | | E O | | | | | | | | autop perfor 1 □ Yes | rmed? 2 No | death? | ompletion of cause of 2 □ No | |
| /Ita | lcian: The lav certificate has ector, page 2 | Be | 25. Was case referred to medical examiner? | | | | | | e of Death | (Check only o | | | 20110 | |
| 0 | Physical this call dire | ၉ | 1 Yes 2 No | | patient 2 | · | L SILL DOA | | | | | ☐ Other (Speci | fy) | |
| Division of | ding 1 | ig | 27. Manner of Death 1 Natural 5 Pending | 1 ' | n, Day, Year) | 28b. Time of Injury | | Injury at Work? 1 ∐Yes 2 ∐ | - 1 | 28d. Describe h | ow injury | occurred | | |
| <u> S</u> | deatl deatl ctor: y the | ficat | 2 Accident investig 3 Suicide 6 Could n | ot be | of Injury - At ho | me, farm, stre | et, factory, offi | | - | P8f Location /9 | Street and | Number or Run | al Route Number, | |
| 2 | al or a after a after a l Dire | Certification: | 4 ☐ Homicide determi | building | g, etc. (Specify | y) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | City or Tow | n, State) | ranio di Girian | arroute rearroes, | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p. | edical (| 29a. Certifier (Check only Medical 6 | g Physician: To the b Examiner: On the ba | pest of my kno | wledge, death | occurred at th | ne time, date a | nd place, a | and due to the | cause(s) a | and manner as | stated. | |
| | the H | Medi | une) | and manne | er stated. | | | | | | | | | |
| | 6 ≥ 6 8 | - | 29b. Signature and title of certifier | indone_ | | | | iense number | | | | signed (Month, | O(A) G | |
| • | XX |) | 30. Name and address of person v | | of death /lte- | 23a) /Time 1 | | 000010 | | | 031 | 07/20 | 7 | |
| • | 1,50 | | Arun Bhandari | M D 2 | OO3 Mad | lical E | 01/27.777 (| Ste G60 |). Anı | napolis | . MD | 21401 | | |
| | Sta | te | 31. Date filed (Month, Day, Year) MAR U 5 2 | 000 32. Re | gistrar's Signa | ture / | el. I | | , | | , 111 | | | \neg |
| | Registra | ar | 2 GV MAIN | UUS Kerne | m p | - Spar | Charles . | | | | | | | |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 0 5 2009

2. Registrar's Signature

Www. B. Aparles

| | | | State of | of Maryland / E | Depai | rtment of H | lealth a | nd Men | tal Hy | giene | | |
|--------------------------------|--|----------------|---|---|-------------------|---|----------------------|------------------------|---------------------------|--------------|-----------------|--|
| | | | State Registrar | | Cert | ificate of L | Death | | | Reg. No. 2 | 009 | 09020 |
| н | Physicia | an | Decedent's Name (First, Middle, Last) | | | | | | Date of Dea | Day | Year | 3. Time of Death |
| | /Medic | al | Eunice L. Brevard 4a. Facility Name (If not institution, give street and no | umher) | | 4b. City, Town, or | Location of | | rch 3 | | unty of Death | 10:46 A M |
| j . | Examin | er | Bowie Health Care Cente | | 1 | Bowie | | | | | | orge's |
| T. | Funeral | | 5. Social Security Number 6. Sex 1 ☐ M 2 ∏ F | 7. Age (In yrs. last bir | thday) | If Under 1 Year Months Days | If Under 24 Hours | 4 Hrs. 8. D Min. (/ | ate of Birt Month, Da | h | 9. Birth | nplace (State or Foreign intry) |
| | Director | | 200-20-0817 Usual Residence of Decedent | 95 | Yrs. | | | Dес | . 26 | , 1913 | Flor | ida |
| | yland now | | 10a. State 10b. County | 10c. City, Towr | n or Loca | ation | | | | | | 10d. Inside City Limits |
| | Ba-fst | Director | Maryland Prince George | 's Laure | 1 | | | | | | | 1 XXYes 2 □ No |
| | with th | | 10e. Street and Number | | | 10f. Zip Code | | | | | of What Cou | intry? |
| | ns 23a | Funeral | 11. Marital Status 12. Was Deg | edent Ever in U.S. | 13. W | 20708 as Decedent of Hi | spanic Origi | in? (Specify) | Yes or No- | USA 14. | Race - Amer | ican Indian. |
| 9 | or iten | | 1 Never Married 2 Married 1 Yes | orces? 2X No | | as Decedent of Hi Yes, specify Cuba □Yes 2 XNo | n, Mexican, Specify: | Puèrto Ricar | n, etc.) | | Black, White | |
| 003 | be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be natified at | d by | 3 ⚠ Widowed 4 Divorced If Yes, G Year or I | Dates: | | | | | | | ecify: Bla | |
| 15 | n 72 h "natu | Completed | 15. Decedent's Education (Specify only highest grade completed, | | (Give ki | ent's Usual Occupa ind of work done d O NOT use retired | luring most o | of working | | 16b. Kind | of Business/II | ndustry |
| 212 | y with giene. | mo: | Elementary/Secondary (0-12) College (| 1-4or 5+) Hot | | laker | | | | Own H | lome | |
| | 0 = 0 \$ | Be C | 17. Father's Name (First, Middle, Last) | | | | 18. Mother | 's Name (Firs | st, Middle, | Maiden Su | rname) | |
| <u>yla</u> | 2 should be filed and Mental Hygi Is marked other aumatic event, II | 욘 | Alfonse Dean | | | | | Belle | | | | |
| Mai | d 2 sh Ith and 17 Is n traun | | 19a. Informant's Name/Relationship (Type. Print) James E. Brevard, Jr. / | 1 | | Address (Street a | | | | - | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic evonce. | | 20a. Method of Disposition | | | ition (Name of atory or other place | | Date | | | ion - City or T | |
| <u>E</u> | Pages nent of I ant: If ite ury or o | | 1 XBurial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) | State | | emetery | | 3/7/20 | 09 | Pitts | burgh, | PA |
| 3alt | permit. Departi Importi any inji | | 21. Signature of Funeral Service Licensee | | | Name and Addres | | | | | | al Home |
| | <u>.</u> | | 200 Don't Enter the disease or commissions that | councid the death. Do r | | 000 Anna | | | | | 20715 | Approximate |
| | | | 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final | each line. | not enter | r trie mode of dylin | | | | rest, | 1 | Interval Between Onset and Death |
| | hysician /Medical | | disease or condition resulting in death) | s a consequence | of): | | 7/7 | -ear | ~ | | | years |
| | Examiner | | . D | 48 hha | 10 | 201 | | | | | | months |
| | sit ed | iner | Sequentially list conditions, if an, leadin to immediate cause. Enter Underlying Cause (Disease or injury | (or as a consequence | of): | 1 | | | | | | _ ^ |
| | xecur n and al-tran | Examiner | that initiated events c. | (or as a consequence of | 1 14 of): | | | | | | | years. |
| 8760 | certificate be executed ading physician and ise as the burial-transit | dical E | d | | | | | | | | | |
| 9 | ng phy | Medi | IF FEMALE: | | | | | | | | | |
| Box | eatn certilic attending pl for use as t | Physician/Me | 23b. Was decedent pregnant 1 Live | tcome of pregnancy birth 2 Fetal death | | Ectopic pregnancy | / | | | 230 | . Date of deli | very Day Year |
| o [| Ine law requires mat me deam ate has been signed by the atter bage 2 should be detached for u | ysic | 1 ☐ Yes 2 🕱 No 4 ☐ Prei 9 ☐ Unknown 9 ☐ Unk | nant at time of death nown | 5 □ | Other (specify) | | | | | | • |
| S, D | s mar ned b | by Ph | Part II. Other significant conditions contributing to | leath but not resulting in | n the unc | derlying cause give | en in Part I. | | 23e. Did to | bacco use | contribute to | the cause of death? |
| ğ | w require been significations should by | | | | | | | _ | 1 🗆 Y | es 2001 | lo 3□ Pro | obably 4 ☐ Unknown |
| Vital Record | nas be nas be | Completed | | | | | | | 24a. Was autop | sy | prior to c | topsy findings available ompletion of cause of |
| a H | ircran: The law certificate has ector, page 2 s | | | | | | | | | 2. No | death? | 2 🗆 No |
| = | sicial s certif lirecto | Be c | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ | Inpatient 2 ☐ ER/Ou | utnationt | 3 DOA Othe | | of Death (Ch | | | Other (Spec | |
| ָם ר | g rny ter this neral d | <u>ان</u> کو | 27. Manner of Death 28a. Date | of Injury 28b. 1 | Time of Injury | 28c. Injury Work | | | | ow injury o | | ny) |
| Sior . | endin eath. or: Af the fur | atio | 2 Accident investigation | | | M 1 1 | Yes 2□N | lo | | | | |
| Division of | or An after d Direct in by | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place build | e of Injury - At home, fa ling, etc. (Specify) | rm, stree | et, factory, office | | | ocation (5 City or Tou | | umber or Ru | ral Route Number, |
| | spiral lours a neral I | | 29a. Certifier Certifying Physician: To th | e best of my knowledge | e, death | occurred at the tin | ne, date and | d place, and o | due to the | cause(s) ar | d manner as | stated. |
| : | To me hospital or Attending Frysicians. With a Funeral Director: After this certification completely filled in by the funeral director, it | edical | (Check only one) 2 Medical Examiner: On the and ma | basis of examination an iner stated. | nd/or inve | estigation, in my o | pinion, death | h occurred at | t the time, | date and pla | ace, and due | to the cause(s) |
| , | vith To t | M | 29b. Signature and title of restifier | 201 441 | N | 29c. License | number | 100 | 2 | 29d. Date s | igned (Month | , Day, Year) |
| | ands | V | Kayrould | VI 1911 | () (T) = - 5 | | | 108 | 2 | 91 | 11 | / |
| | 1200 | | 30. Name and address Sperson who completed cau Rakesh Arora, M.D. 143 | se of death (Item 23a) : 300 Gallant | | | ite 2 | 22 Bow | vie. N | 4D 207 | 15 | |
| | Sta | te | 31. Date filed (Month, Day, Year) 32. | Registrar's Signature | | | | 30W | | | | |
| | Registr | ar | MAR 05 2009 Sense | a B. S. | all | | | | | | | |

09-01617 Shirley Burgess

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 09021

| inley burgess | 1-For State Certificate Certificate C | | Reg. No. | |
|--|---|---|--|--|
| Physician/ | Registrar 1. Decedent's Name (First, Middle,Last) | | 2 Date of Death | 3. Time of Death 1848 hrs |
| ledical Examiner | Shirley Burgess 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Deal | Month Day Year February 24, 2009 | |
| | 1110 Madison Street #B - 2 | Annapolis | Anne Arunde | 1 |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24H Months Days Hours Mi | Fore | |
| | Usual Residence of Decedent | | 1 | 10d. Inside City Limits |
| faryland 28a-f show any Latonce. ector | 10a. State 10b. County Maryland Anne Arundel Annapo | | | 1 XYes 2 No |
| h the Maryland 3a or 28a-f sho polified at once. I Director | 10e. Street and Number 1110 Madison Street #B2 | 10f. Zip Code 21403 | 10g. Citizen of What Co USA | untry? |
| death with r items 23. nust be no | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No | Vas Decedent of Hispanic Origin? (f Yes, specify Cuban, Mexican, Puer | Specify Yes or No- to Rican, etc.) 14. Race - Ame White, etc. | erican Indian, Black, |
| urs after d tural", or aminicr in | 3 Widowed 4 XDivorced If Yes, Give Year or Dates: | Yes 2 X No specify: ent's Usual Occupation (Give kind o | f work done 16b. Kind of Business | lack s/Industry |
| 5-0036 ed within 72 hour 1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/ | Elementary/Secondary (0-12) | most of working life. DO NOT use re eautician | Self E | mployed |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director | Daniel Brown | Louis | ne (First, Middle, Maiden Surname) e Johnson | |
| MD 21 ad 2 should: tht and Men at 27 is man animatic ev | Georgia Hunter(Sister) 326 | 7 Susan Circle | r Rural Route Number, City or Town, Sta N. Park City, | I1 60085 |
| F F F | 1 X Burial 2 Cremation 3 Removal from State crematory or Hope St | . Mark UMC 3 | Date 20c. Location - City Control 20c. Locati | er, Md. |
| Baltimo permit. Page Department of Important: injury or oth | 21. Signature of Funeral Service Licensee 21. Across 13. Rees Moof 8.3 | 821 West St. A | ns Mortuary, P. nnapolis, Md. 2 | |
| Physician | 23a. Part I. Enjer the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. | | c or respiratory arrest, shock, or heart | Approximate Interval Between Onset and Death |
| xaminer | Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Due to (or as a consequence of): | isease | | |
| iner | Sequentially list conditions, if any, leading to immediate cause. Enter Undarying Causa | | | |
| uted nd transit | Ο. | | | |
| 760, cate be executed physician and he burial - transit Medical Ex. | UNPENDED AMENDED | | | |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transing control Certification: To Be Completed by Physician/Medical Especial | | Fetal death 3 Ectopic pres | gnancy 23d. Date of deliv | ery Day Year |
| o.O. Be that the de detached for Phy | | ne underlying cause given in Part I. | 23e. Did tobacco use contribute | produce. |
| S, P.O. uires that the signed by d be detact | | | 1 Yes 2 No 3 P | robably 4 V Unknown autopsy findings available |
| Division of Vital Records, rate of Attending Physician: The law require its after death. al Director: After this certificate has been sized in by the funeral director, page 2 should be prification: To Be Completed | | | | o completion of cause of ? |
| Vital R ysician: T his certific director, p | 25. Was case referred to medical | 26.Place of Death (Che | | |
| of Vit ing Physic After this c uneral dire | 1 Yes 2 No 1 Inpatient 2 ER/Outpati | | rsing Home 5 Residence 6 Ot 28d. Describe how injury occurred | her: Scene |
| ion of Vending Phyeath. the funeral the funeral ation. To | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time | 1 Yes 2 No | | |
| Division ospital or Attending spital or Attending tours after death. Interal Director: After the filter of the function of th | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, s | treet, factory, office building, etc. | 28f. Location (Street and Number or or Town, State) | Rural Route Number, City |
| Division To the Hospital or Attentiviting 24 hours after death To the Funeral Director: completely filted in by the | 1 Z98 Centrer | curred at the time, date and place, a igation, in my opinion, death occurre | and due to the cause(s) and manner as s and at the time, date and place, and due to | tated. the cause(s) |
| To com | and manner stated. 29b. Signature and title of cedifier | 29c. License number | 29d. Date signed (I | Month, Day, Year) |
| | S- Mil Imo | O.C.M.E. | February 25, 2 | 009 |
| Som | 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 1 | 111 Penn Street, Baltimore, | MD 21201 | |
| Stat Registra | | wer | | |

| | | • | For State Registrar | State of | Maryland | | artment <i>rtificate</i> | | | ind M | ental Hyg | iene eg. No. | 009 | 0902 | 2 |
|---------------------|--|-------------------|--|--|--|-----------------------------------|-----------------------------|-------------------------|----------------------------|------------------------|---|------------------------|----------------------------|--|------------|
| | 0, | | 1. Decedent's Name (First, Middle, Last) | | | | | | | | 2. Date of Deal Month | th Day | Yeer | 3. Time of Dea | h |
| | Physici /Medio | | JoAnn nmn | Biver | ıs | | | | | | March | 13, | 2009 | 7:00 A | М |
| | Examir | | 4e. Fecility Name (If not institution, give s | treet and numb | ber) | | 4b. City, 1 | Town, or | Location o | f Death | | | County of Dec | | |
| | | | 3119 National P | | | | | cock | | 0.4 Usa | | | shingt | | |
| | Funeral | | 5. Social Security Number 6. Sex 212-44-6696 1□ | M 2√F 7 | . Age (In yrs. I | as <i>t birthd</i> ay) 52 Yrs. | If Under Months | Days | If Under a | Min. | B. Date of Birth (Month, Day, March 1 | Year) | 947 NO | rthplece (State or For | eign |
| | Director | | Usual Residence of Decedent | | |) | | | | | Haren 1 | , | 7 7 2 1 | | |
| | yland | | 10a. State 10b. County | | 10c. City | r, Town or Lo | cation | | | | | | | 10d. Inside City Lin | |
| | a-f et | tor | MD Washingto | on | Har | ncock | | | | | | | | 1 □ Yes 2 √ | No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 1 | | en of What C | country? | |
| | 23a | | 3119 National Pike | | | | | 1750 | | | | USA | | 71 | |
| | tams | Funeral | 11. Wantai Status | Armed Ford | | S. 13. | Was Deced If Yes, spec | ent of Hi ify Cuba | spanic Orig n, Mexican | gin? (Spi i, Puerto | ecify Yes or No- Rican, etc.) | | Black, Wh | erican Indian, ite, etc. | |
| 36 | 72 hours after death with the Maryland "natural", or itams 23a or 28a-f ehow odical Examinational beneditied at | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 If Yes, Give Year or Dat | tes: | | 1 ☐ Yes 2 | No No | Specify: | | | | Specify: Wi | nite | |
| 8 | hour | ed t | 15. Decedent's Educ | | | 16a. Dece | dent's Usua | I Occupa | ation | | | | d of Busines | | |
| 15 | | plet | (Specify only highest grade Elementary/Secondary (0-12) | College (1- | 4or 5+) | (Give | kind of wor DO NOT us | k done d e retired | luring most) | t of work | ng | | | | |
| 212 | d within giene er then | Completed | 11 | | , | Coo | k | | | | | | staura | nt | |
| g | be filed ital Hygied of other event, II | Be (| 17. Father's Name (First, Middle, Last) | | | | | | | | (First, Middle, | Maiden : | Sumame) | | |
| yla | | 2 | John Moore, Jr. | | | | | | | | 1azzel | | T 01 11 | 7: 0:40 | |
| Maryland 21215-0036 | O1 00 - 01 | | 19a. Informant's Name/Relationship (Type | | | | | | | | al Route Number | | | ZIP Code) | |
| | Health Health tem 27 | | Roger L. Bivens/Hus | Spand | 20b. P | lace of Dispo | sition (Nam | ne of | T | | | | | r Town, State | - |
|) O | 00== | | 1 Burial 2XXCremation 3 R | emoval from S | 1210 | emetery, cre | matory or ol | ther plac | | 2/15 | | | nsburg | | |
| Baltimore, | | | ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Signature | ne () | PILLT | | - | _ | | | 1 West | | | | |
| Ba | permit. Departr Imports any inju | | | H. K.en | | | | | | | | | | 21750-0368 | |
| - 1 | Physician /Medical Examiner | niner | disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury | | or as a conseq | uence of): |)(_(| - (Alco | | igne | Canc | | omo | 4 6 in as | Tu |
| 68760, | icate be executed physician and s the burial-transit | edical Examiner | that initiated events resulting in death) Last | Due to (d | or as a conseq | uence of): | | | | | | | | | |
| O. Box | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 1 ☐ Live bi | come of pregna rth 2 Feta ant at time of d | I death 3[| ⊒Ectopic pr ⊒ Other (sp | | | | | 2 | 23d. Date of d Month | elivery Day Year | |
| rds, P | w requires that been signed I should be det | by | Part II. Other significant conditions cor | ntributing to de | ath but not res | ulting in the t | underlying c | ause giv | en in Part I | , | 23e. Did to | | V | to the cause of death Probably 4 Dunkr | |
| I Records, | The ate h | Completed | | | | | | | | | 24a. Was autop perfor 1 Yes | sy | prior to | autopsy findings avai o completion of cause es 2 \sum No | able of |
| Vital | Physician: The this certificate ral director, page | Be (| 25. Was case referred to medical examiner? | descrite! | | | | 0" | | of Deat | h (Check only o | | | | |
| of | this al din | 2 | 1 Tes 20XNo | _ | | ER/Outpatie | | | 4 LI NI | ursing Ho | ome 5 K Resid | | Other (Sp | pecify) | |
| OU C | | lon | 27. Manner of Death 1 Natural 5 Pending investigation | 28a. Date o (Monti | h, Day Year) | Injury | M | 8c. Injur Wor | yal k? Yes 2□ | No | 200. Describe ii | iow injur | y occurred | | |
| Division | or Attendate death | Certification; | 2 Accident Investigation 3 Suicide 6 Could not be determined | | of Injury - At h | | | | | | 28f. Location (S City or Tox | Street an vn, State | d Number or) | Rural Route Number, | |
| | the Hospitel hin 24 hours the Funerel npletely filled | edical C | 29a. Certifier (Check only one) 2 Medical Exami | sicien: To the ner: On the ba and mann | asis of examina | owledge, dea ation and/or i | th occurred nvestigation | at the tin , in my o | ne, date ar pinion, dea | nd place, ath occur | and due to the ored at the time, o | cause(s) date and | and manner place, and d | as stated. ue to the cause(s) | |
| | To th withir To th comp | × | 29b. Sign ture are title of certifier | 1 | | 9 | 290 | c. Licens | e number | 00 100 | | 29d. Dat | e signed (Mo | nth, Day, Year) | [10]54 |
| | | | Mary 11 | / | | | 100 | 1. | 146 | 4 | (3) | 10 | ouncl | 1 13 20 | 0 |
| | | | 30. Name and address of person who co | ompleted caus | e of death (Iter | n 23a) (Type | , Print) | 110 | | 20 | Λ i | , - | 1 | × | 8 |
| | | | Hind Hours | 000 | egistrar's Signa | atura | | 113 | 0 | Ob | H (| _ (| · JHO | gersin | JW. |
| | St | ate | 31' Date filed (Month, Day, Year) | 9 | was tall | 9. 400 | akad | | | | | | ' /Y | 10 711 | + C |

2k

| | | - | For State of Maryland 1 - State Registrar | | tificate of D | | | Reg. No. | 711114 | 09023 |
|---|---|-------------------|--|--------------------------------|---|---|-------------------------------------|--------------------------|-----------------------------------|--|
| | | | 1. December Name (First, Middle, Last) | - | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| | ysicia /ledic | al l | AllEN HENRY | Co | HEY, JR | | MAR | H | 10 250 | <u> </u> |
| | amin | er | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or I | | | 40. | County of Deat | n |
| | | | The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. le | ast birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir | th | 9. Birt | hplace (State or Foreign |
| Fun Dire | | | 216-56-1070 1 □XM 2 □ F 59 | Yrs. | Months Days | Hours Min. | 10/28/ | 1949 | Con | MD MD |
| yland | ta | | Usual Residence of Decedent 10a. State 10b. County 10c. City | , Town or Lo | cation | | _ | | | 10d. Inside City Limits |
| e Mar 3a-f s | ified | Director | MD ST. MARYS CALI | FORNI | | | | | | 1 ☐ Yes 2X No |
| nith th | oe no | Dire | 10e. Street and Number | | 10f. Zip-Code | | | | zen of What Co | untry? |
| eath v | ust k | eral | 23315 LAKEVIEW DR. | 3 13 1 | 20619 Was Decedent of His | spanic Origin? (Spa | ecify Yes or No | | SA 14. Race - Ame | rican Indian, |
| laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show | any injury or other traumatic event, the Medical Examiner must be notified at once. | by Fu | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 【X Divorced 12. Was Decedent Ever In U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: | | Was Decedent of His If Yes, specify Cubar 1 □ Yes 2 XNo | n, Mexican, Puerto Specify: | Rican, etc.) | | Black, White Specify: | e, etc. WHITE |
| Maryland 21215-0036 at 2 should be filed within 72 hours aff the and Mental Hygene. 27 is marked other than "natural", or | lical E | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give | dent's Usual Occupa kind of work done d | luring most of work | ing | 16b. Ki | nd of Business | /Industry |
| 121 within than " | e Mec | Idm | Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ | | DO NOT use retired) TRICAL EN | | | GO' | VERNMEN | Т |
| filed v | int, th | | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | e (First, Middle | e, Maiden | Surname) | |
| lan lid be lental | ic eve | To Be | ALLEN H. COHEY, SR. | | | MARY TI | HERESA | SCHA | UBER | |
| faryla 2 should and Men is marke | ıumat | | 19a. Informant's Name/Relationship (Type. Print) | | ng Address (Street a | | | | | Zip Code) |
| e, M 1 and 2 Health em 27 i | her tra | | MARGARET KAUFMAN/SISTER | | WATSON RD | | JILLE, | | 1617 cation - City or | Town State |
| MOFE Pages 1 nent of H nt; If ite | y or ot | | 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State | emetery, crer | osition (Name of matory or other place | e) | | | RCH HIL | |
| Baltimore, permit. Pages 1 ar Department of Hea Important; If item: | uny injur | | 21. Signature of Funeral Service Licensee | , 22 F | 2. Name and Addres | ss of Facility ELFENBEII | N & NEW | NAM | FUNERAL | |
| | 10 01 | | 23a. Part 1. Enter the disease, or complications that deased the death | | 30 SPEER er the mode of dying | | | | 21020 | Approximate Interval Between |
| Physic /Med | | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A public (or as a concept) | | MONJA | | | | | Onset and Death DAYS |
| Exami | _ | | A c = T | MYF | LOGENO | US LE | UKEN | MIA | | MONTHS |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | uence of): | 2000740 | | | | | |
| cuted | transit | Examiner | Cause (Disease or injury that initiated events c | ioneo off: | | | | | | |
| 50, oe exe cian al | as the burial-transit | | resulting in death) Last Due to (or as a consequ | gence on, | | | | | | |
| 68760, ifficate be early physician | is the | edic | d | | | | | | | |
| A Series | | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown | l death 3 [| ☐ Ectopic pregnancy ☐ Other (specify) | y | | | 23d. Date of de Month | livery Day Year |
| ds, P.O. uires that the calculations signed by the | ld be detai | ρ | Part II. Other significant conditions contributing to death but not res | ulting in the | underlying cause giv | ven in Part I. | | | | to the cause of death? |
| Division of Vital Records, or Attending Physician: The law requires to after death of the this certificate has been signed injuredor: After this certificate has been signed. | page 2 should be d | Completed | | | | | 24a. Was auto perf 1 Yes | | prior to death? | utopsy findings available completion of cause of |
| Vital sician: The | director, | Be (| 25. Was case referred to medical examiner? | | Othe | 26. Place of Deat | | | | |
| of \ Physic | aldir | 2 | 1 ☐ Yes 2 ☐ No ☐ No ☐ No ☐ 1 ☐ Impatient 2 ☐ 27. Manner of Death 28a. Date of Injury | ER/Outpatier 28b. Time of | IL 3 DOA | 4 - Nuising no | me 5 ☐ Res 28d. Describe | | | ocify) |
| On Oil | funer | tion | 1 | Injury | Work | | | , | • | |
| Division of Vita To the Hospital or Attending Physician: within 24 hours after death. | d in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At ho building, etc. (Specify | | reet, factory, office | | | (Street ar wn, State, | | Bural Route Number, |
| Hospital 24 hours Funeral | etely fillec | edical C | 29a. Certifier (check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examina and manner stated. | wledge, deat tion and/or ir | h occurred at the tin | ne, date and place opinion, death occu | , and due to th rred at the time | e cause(s e, date an |) and manner a d place, and du | us stated. ue to the cause(s) |
| To the within 2 | зошріє | Mec | 29b. Signature and title of certifier | | 29c. License | | | 29d. Da | te signed (Mon | th, Day, Year) |
| 40 | | | Christiant: Meye | 1 | 106 | 01760 | 1 | MI | ARCH | 10 2009 |
| | | | 30. Name and address of person who completed cause of each (Iter | m 23a) (Type | | | | olfe S | t. Baltim | ore, MD, 21287 |
| n | Sta | te | 31. Date filed (Month, Day, Year) 32. Registrar's Signar | ture | 1.4.1 | | | J.10 0 | -, - | ,, |
| R | egistr | | MAR 1 3 2009 | A. 1 | part! | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State 8- 3/12/09, M.S. Kent Co. Amended#12 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 MARCH 8, **Physician** 17:53P M VICTORIA LEE COLEMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER | Hours | Min. | Hours | Min. | Min. | Months | Days | Hours | Min. | Min. | Min. | 5/1/1952 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F 56 Director 214-60-8403 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be modified at 1 ☐Yes 2 No Director CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? should be filed within 72 hours after death with ond Mental Hygiene.
marked other than "natural", or items 23a or 21620 USA 8890 FAIRLEE RD. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black. White, etc. Armed Forces □Yes 2□Ko 1970-Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 Widowed 4 Divorced Year or Dates: 1971 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MACHINEST MANUFACTURING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fill the and Mental H 7 is marked off ALBERT LEE COLEMAN CATHERINE ROSLIE BOULTER ం 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 Is WILLIAM COLEMAN/HUSBAND 8890 FAIRLEE RD. CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page:
Department o
Important: If
any injury or injury or WESLEY CHAPEL 3/13/2009 ROCK HALL, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Kuk of 130 SPEER RD. CHESTERTOWN, MD 21620 Q 23a. Part 1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Anoxic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Orche Sequentially list conditions, if any, leading to initine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed the burial-transi Due to (or as a consequence of) Box 68760, physician Physician/Medical use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) P.O. I ned by the a detached for 1 □Yes 2 □No 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Troct autopsy performed this certificate 1 ☐ Yes 2 ☐ No 2No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2A No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ funeral 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day, Year) Injury Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Hospital on 24 hours af e Funeral D 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

Ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 6, ^{Day}2009 Year **Physician** M. Brun Chiles 12:40a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery Bedford Court Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🖺 F 101 Yrs May 4, 1907 Switzerland Director 578-46-0751 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes XX No Directo MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3700 International Drive #347 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give Specify: White Completed by 3 XXVidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Luft Max Pfander ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 537, Indian Head, PA 15446 Charles R. Brun / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. March 7, 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. -500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atrial Fibrillation

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f shov

rat", or Items 23a or 28a-f shov Examinar must be notified at

"natural"

of Health and Mental H I Item 27 is marked oth r other traumatic even

by Physician/Medical Examine ending puse as t atter for u det Be Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

MAR

| | resulting in death) | Due to (or as a consequ | uence of): | | | | |
|---|--|--|----------------------------|--------------------------------------|--|------------------------------------|-----------------|
| xaminer | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of the consequence o | • | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown | 23c. If yes, outcome of pregna 1 | I death 3 Ect | opic pregnancy er (specify) | 1 | 23d. Date of delivery Month Day | Year |
| ed by Ph | Part II. Other significant conditions of Anemia | ontributing to death but not res | ulting in the underly | ying cause given in Part I. | 23e. Did tobacco | o use contribute to the cau | |
| Complet | Hypertension | | | | 24a. Was an autopsy performed? | | ion of cause of |
| Be (| 25. Was case referred to medical examiner? | | | | eath (Check onfy one) | | |
| | 1 Yes 27√No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatient 3 | □ DOA Other: 4 🖾 Nursing | Home 5 ☐ Residence | 6 ☐ Other (Specify) | |
| ation: | 27. Manner of Death 1 XX atural 5 ☐ Pending 2 ☐ Accident investigation | | 28b. Time of Injury | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how inj | jury occurred | |
| Sertific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, street, f y) | actory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Rou ate) | te Number, |
| Medical Certification: To | | nysician: To the best of my kno niner: On the basis of examina and manner stated. | | | | | |
| Me | 29b. Signature and title of certifier | | Λ | 29c. License number | 29d. [| Date signed (Month, Day, | Year) |

D45285

March 6, 2009

State Registrar

Wilkinson Ninala 344 University Blvd. West Suit #113, Silver Spring, MD 20901 31. Date filed (Month, Day, Year) Registrar's Signature 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours after death

To the Funeral Director:
completely filled in by the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Andrew Joseph Cummings, Sr. March 6, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □₀M 2 □ F New york 092 24 6616 Sept 16, 1931 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Prince George's Suitland 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 4402 Ridge Crest Drive 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married Yes 2 No Korean Year or Dates: War 1 ☐ Yes 2 👿 No Specify. Specify: White 3 Widowed 4 Divorced War 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Field Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Thomas Cummings Gwendolyn Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Cummings, (WIFE) 4402 Ridgecrest Drive, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗓 Femation 3 ☐ Removal from State Lee Crematory March 11, 2009 | Clinton, No., 2009 | 22. Name and Address of Facility Lee Fuenral Home, Inc 6633 01d 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 01555 Jessica Unicroz Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) septic Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1mPNom Due to (or as a consequence of) yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No autopsy 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

physician

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'm Medical Examination and be mailified at

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Baltimore, Maryland 21215-0036

/Medical

burial-tra

Physician/Medical þ Completed Be

Examine

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the as attending properties for use as is certificate has been signed by the director, page 2 should be detached Certification: To After 24 hours after death. Funeral Director: A filled in by the

Hospital or Attending Physician: The law requires that the death certificate be execu-

P.O. Box 68760.

Division of Vital Records.

the within 2 To the I

1 Tes 2 No 27. Manner of Death

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation

6 ☐ Could not be

28b. Time of

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) 09

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)
HO KANIAN 7503 SUTTANTS Rol. Clinton, HD 20735 32. Registrar's Signatur

28a. Date of Injury (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav **Physician** MAOL SMITH CROTTS MARCH 2009 5:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, May 6, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🕱 F Washington DC 220-34-4793 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Carroll Detour Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21725 USA 8200 Sixes Bridge Road Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine any since 1 Never Married 2 Married Specify: white Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farm Horse Trainer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Filmore Smith Eleanor Kolopinski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dexter D. Crotts, husband 8200 Sixes Bridge Road, Detour, MD 21725 20b. Place of Disposition (Name of Scandiday, crematory or other place)
Carroll Crematory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/3/2009 Winfield, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 136 E Baltimore St, Taneytown, MD 2 787

Inter the mode of dying, such as cardiac or respiratory arrest, Applications of the construction of the c 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final SUBDURAL HEMATUMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed As hours after death.

Funeral Director: After this certificate has been signed by the attending physician and energy filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2,2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗷 No 2/24/09 1400 Fell & Struck Head 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) **Keymal**, **MD** determined 4 Homicide Home 8200 Sixes Bridge Rd. within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO063498 WIL well mo 3/2/09 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. FREDERICK, MD LAKHVINDER WADHWA 400 W. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State park Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month 2009 **Physician** 3:10P March Minnie Lee Childers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Northampton Manor Health Care Center Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 📆 F 91 Yrs. 577-18-0951 Feb 15 1918 Brunswick, MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 √ Yes 2 No Frederick Brunswick Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1201 Maple Terrace Lane, Apt. 204 21716 death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after I Hygiene. Other than "natural", or Ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fit Health and Mental H Daniel Woods Leda Mae Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a t: If Item 27 Is y or other trau 6685 Seagull Court, Frederick, MD 21703 Sheree Stevens, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once. Resthaven Memorial Gardens 3/10/09 Frederick, MD 21. Signatura 11 Jun / Service Lio , see 22. Name and Address of Facility
John T. Williams Funeral Home Williams, Owner Barbara A. 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CORONARY DIGGAST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 3□ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely (Check only one) and manner stated. 29c. License number D + 7 1 6 9 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9th AVE, BRUNSWICK, NW 21716 ino CHANTING ITO 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Mrs 271-2 . Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® | For State Registrar Certificate of Death Rea. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year 4:10 AM **Physician** 2009 March 2 rnna bell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcest Number 6. Sex Ber erlin Kehabi litation Date of Birth (Month, Day) Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 X F 82 220-26-3080 10/11 192 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 No Completed by Funeral Director Worces 'oco mo 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code U.S. A 2185 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 No 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: ac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOK ev 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be irginia 2 ian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 Is any injury or other tree once. 21851 50r Oyster TR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cremation 12009 over * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 917 W. Isabella Strat Smith Salesbury Mo 21801 tuneral in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVO disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 ursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Items 23s or 28e-f show

5

"naturel"

than "

I Hygie

and Mental F

Pages 1 and 2 should be

permit.

treumatic event, the Medical Examiner nust be notified at

Medical Certification; To Be Completed by

or Attending Physicien: The law requires that the death certificate be executed inding physician and use as the burial-transit been signed by the a should be detached t certificate director, this After thi To the Funers To the Funerel Dire To the Hospitel

Division of Vital Records, P.O. Box 68760,

State

examiner' 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

65/1

MAR 06

31. Date filed (Month, Day, Year)

5 Pending investigation 6 Could not be determined

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

D 63199

Salisbun

Or .

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 03/03/00/

ddress of person who completed cause of death (Item 23a) (Type, Print) Y Umra

Eastein 6.14

Shore park

Registrar

DK

| | 1 | For State Registrar | | State of | waryian | • | artment of F rtificate of I | | | grene Reg. No. | 009 | 09031 |
|--|-----------------------------|--|-----------------------------------|--|-----------------------------------|----------------------------|---|--|-------------------------|-------------------|-------------------|---|
| Physician | | 1. Decedent's Name | | Last) | | | | | 2. Date of Dea Month | ath Day | Year | 3. Time of Death |
| /Medical | 1 | Alan J. D | | | | | | | March March | | | 7:09 a ^M |
| Examine | | | | give street and num | ber) | | | Location of Death | | | inty of Death | |
| | | #2 First 5. Social Security N | | S. Sex | 7. Age (In yrs. I | ast hirthday) | Indian If Under 1 Year | If Under 24 Hrs. | 8. Date of Birt | h | narles | place (State or Foreign |
| Funeral Director | | 212-54-31 | | 1 XM 2 □ F | 57 | Yrs. | Months Days | Hours Min. | June 16 | y, Yea <i>r)</i> | 1 Mai | place (State or Foreign ntry) ryland |
| | Usual Residence of Decedent | | | | | | | | | | | |
| show | _ | 10a. State | 10b. County | | | | | | | | 1 | 10d. Inside City Limits 1 X Yes 2 □ No |
| Ba-f | 25 1 | Maryland | Charl | es | 11. | dian 1 | | | | 10a Citizon | of What Cour | |
| a or S | 5 | 10e. Street and Nur | | | | | 10f. Zip Code 2064 | 0 | | U.S. | | iti y : |
| fler death with the Marritems 23a or 28a-f's | ם ב | #2 First 11. Marital Status | prieer | 12. Was Deced | dent Ever in U.S | 3. 13. | | ispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- | | Race - Americ | can Indian, |
| ifter d | | 1 Never Marri | ied 2□ Marrie | Armed Ford | ces? 2 [चु⊁No | | | | Rican, etc.) | | Black, White, | etc. |
| ral", o | 5 | 3 🗆 Widowed | 4 X Divorced | If Yes, Give Year or Da | | | 1 □ Yes 2 🌠 No | Specity: | | Spe | ecify: Wh: | ite |
| ygiene. ner than "natura it, the Medical E | בַּנַבַ | (Spec | 15. Decedent's cify only highest | Education grade completed) | | (Give | dent's Usual Occup kind of work done | during most of work | ing | 16b. Kind o | of Business/In | dustry |
| vithin sne. than ' | - | Elementary/Seco | ondary (0-12) | College (1- | 4or 5+) | | DO NOT use retired Orer | 1) | | Cons | structi | ion |
| Hygie ther ther ther ther ther | 3 | 17. Father's Name | (First, Middle, L | ast) | ļ | Lau | rer | 18. Mother's Name | e (First, Middle, | | | LOIT |
| d be fill ental H ked oth c even | | John Sull | | | | | | Lorrain | ne Finc | h | | |
| should Ind Men | - | 19a. Informant's Na | ame/Relationshi | p (Type. Print) | | 19b. Mailir | ng Address (Street | and Number or Rui | al Route Numbe | er, City or To | wn, State, Zip | o Code) |
| alth alth a 27 is | , | Tina Peck | | S | ister | 8790 | OLd Keen | e Mill Ro | l., Spri | nfield | d, Va. | 22152 |
| of He fitem | | 20a. Method of Dis | | | 20b. P | lace of Dispo | sition (Name of matory or other plac | e) March 7 ral Servi | Date 7 2000 | | on - City or To | |
| ment tant: If fury o | | 4 Donation | 5 ☐Other (Sp | | Met | ropol | itan Fune | ral Servi | .ce ²⁰⁰⁹ | Alexa | andria, | , Virginia |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Moulcal Examination in a fired and once. | | 21. Signature of Fu | uneral Service | ensee // | M006 | 68 | | Funeral H | | | | |
| | + | 23a Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate | | | | | | | | | | Approximate |
| Dhysisian | | shock, or heartfailure. List only one cause on each line. Immediate Cause (Final disease or condition a. Cov Cee | | | | | | | | | | |
| Physician /Medical | | disease or condition resulting in death) | | a | or as a consequ | | Cec | ricec | 1 | | | |
| Examiner | | | | | , | , | | | | | | |
| P # | | Sequentially list co if any, leading to in cause. Enter Under | onditions, omediate erlying | Due to (c | or as a consequ | ience of): | | | | | | |
| ifficate be executed g physician and as the burial-transit | Cyalliller | Cause (Disease or that initiated events resulting in death) | r injury s | c | | | | | | | | |
| be excian a | 0 | resulting in death) | Lasi | Due to (c | or as a consequ | ience of): | | | | | | |
| g physicia as the bur | 20 | | , | d | | | | | | | | |
| certific nding p | | IF FEMALE: 23b. Was deceden | | 23c. If yes, outo | ome of pregna | ncy | | | | 23d | . Date of deliv | rerv |
| death | Frigsicialiyis | in the past 12 | months? | 4 ☐ Pregn | irth 2□ Fetal ant at time of d | | ☐ Ectopic pregnanc ☐ Other (specify) _ | y | | | Month | Day Year |
| by the | l ys | 9 ☐ Unknown | | 9 ☐ Unkno | own | | | | | | | |
| gned | y y | Part II. Other signi | ficant condition | ns contributing to dea | ath but not resu | ılting in the u | nderlying cause giv | en in Part I. | 23e. Did to | obacco use o | 3 6 | he cause of death? |
| equire | | | | | | | | | 101 | /es 2 □ N | lo 3 Pro | bably 4 🗌 Unknown |
| law r | Completed | <u> </u> | | | | | | | 24a. Was autop | sy | prior to co | opsy findings available ompletion of cause of |
| slcian: The law certificate has birector, page 2 si | 5 | | | | | | | | perfo 1 ☐ Yes | rmed? 2 No | death? 1 ☐ Yes | 2 🗆 No |
| lcian certifi ector, | ועב | 25. Was case refer examiner? | • | Hospital: | | | Oth | 26. Place of Deat | th (Check only o | ne) | | |
| Phys | 2 | 1 ☐ Yes 2 ☐ 27. Manner of Deat | Γ | 28a. Date o | npatient 2 of Injury | ER/Outpatie 28b. Time o | III 3 LI DOA | 4 LI Nursing Ho | ome 5 Residence 1 | | - ' ' | (fy) |
| th. After | 5 | 1,—Natural 2 Accident | 5 Pending investiga | (Monti | h, Day, Year) | Injury | Wor | k? Yes 2 □No | Zod. Describe i | low injury oc | ouried | |
| Atten r deat sctor: by the | 25 | 3 ☐ Suicide | 6 Could no | ot be 28e. Place | of Injury - At ho | me, farm, str | reet, factory, office | | 28f. Location (S | Street and N | umber or Run | al Route Number, |
| To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the aftendin completely filled in by the funeral director, page 2 should be detached for use a Modical Confidence of the Completed by Directorian Modical Confidence of the complete of the confidence | 2 | 4 ☐ Homicide | 401011111 | buildin | ig, etc. (Specify | () | | | City or Tov | vn, State) | | |
| lospit Hour Luner ely fille | | 29a. Certifier (Check only | | Physician: To the examiner: On the ba | | | | | | | | |
| thin 24 house the Fune of the Fune ompletely file | D . | one) | | and mann | | | | | | | | |
| No or or | 2 | 29b. Signature and | title of certifier | 1 | | | 29c. Licens | e number | | 29d. Date si | gned (Month, | Day, Year) |
| | - | 1/2 | - Mal | Un- | | 00 \ /= | 179 | 83) | 7 | 2/6 | 0107 | 7 |
| 87 | | 30. Name and add | ress of person w | the completed cause | e of death (Item | 23a) (Type, | Print) | Plate | - 1 | 10 | 206 | 46 |
| 114 | | 31. Date filed (Mon | nth, Day, Year) | 32. B | egistrar's Signa | ture | | | -1 | | | |
| State | • | | | | | | arke | | | | | |

| | | | . For | State of Marylan | | | | Mental Hyg | ilene | | |
|----------------------------|---|-------------------|--|---|-----------------------|--|--------------------|--------------------------|----------------------------|---|--|
| | | | State Registrar | | Cei | rtificate of l | Death | | eg. No. 2 | 009 | 09032 |
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | 1000 | 1111 | Tho | | Date of Dea Month | th Day | Year | 3. Time of Death |
| | /Medic | | IDELL D. | DORI | THE | | | 03 | 07 | 2009 | 0540AM |
| 1 | Examin | er | 4a. Facility Name (If not institution, give st | treet and number) | | 4b. City, Town, or | Rocation of Death | 1 | | eROLI | - County |
| ` | | | LORIEN MT A 5. Social Security Number 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1 | 9. Births | place (State or Foreign |
| | Funeral Director | | | M 2ÅF 93 | Vro | Months Days | Hours Min. | (Month, Day Aug. 4, | | Cour Mary | ** |
| и. | ס | | Usual Residence of Decedent | | | | | | | | |
| | arylan show d at | _ | 10a. State 10b. County | 10c. Cit | y, Town or Lo | cation | | | | | 0d. Inside City Limits 1 ☐ Yes 2 📉 No |
| | Ba-f : | Scto | Maryland Montgomery | Dama | scus | 106 7in Code | | | Oc. Citizo | n of What Cour | |
| | a or 2 be no | ğ | 10e. Street and Number | | | 10f. Zip Code | | | log. Citize | II of What Coul | itry : |
| | 72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at | Funeral Directo | 27209 Ridge Road 11. Marital Status | 2. Was Decedent Ever in U. | S. 13. | 21771 Was Decedent of H If Yes, specify Cuba | ispanic Origin? (S | | SA 14 | . Race - Americ | an Indian, |
| ' | r Iten | 필 | 1 □ Never Married 2 □ Married | Armed Forces? 1 ☐ Yes 2 X No | | | | o Rican, etc.) | | Black, White, | etc. |
| 036 | al", o | | 3 Midowed 4 Divorced | If Yes, Give Year or Dates: | | 1 □ Yes 2 汉 No | Specify: | | S | pecify: Whit | e |
| 21215-0036 | 72 ho natul dical | Completed by | 15. Decedent's Educ (Specify only highest grade | ation completed) | (Give | dent's Usual Occup kind of work done | during most of wor | rking | | of Business/In | |
| 2 | Atthin han " | g E | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use retired | • | | _ | ic Scho | 01 |
| | filed within Hygiene. wher than " | ပိ | 12 17. Father's Name (First, Middle, Last) | | Schoo | <u>1 Teacher</u> | | ne (First, Middle, | Syst e Maiden St | | |
| and | d be f | 9 Be | Ernest Davis Duvall | | | | Mamie Al | ica Mati | | | |
| Maryland | 2 should be and Mental is marked caumatic even | မ | 19a. Informant's Name/Relationship (Typ | | 19b. Mailir | ng Address (Street | | | | own, State, Zip | Code) |
| | ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the M-cloal Examiner must be notified at | | Michele Cerulli - | Personal Rep | . 2720 | 5 Ridge R | load. Dam | ascus. M | arv1a | and 20 | 872 |
| Baltimore, | of He of He item | | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re | 20b. F | Place of Dispo | osition (Name of matory or other place | | Date 0/2009 | | tion - City or To | |
| Ĕ | Pages nent of I ant; If its ury or o | | 4 Donation 5 Other (Specify) | | | y Method: | ist Cem. |] | | cus, Ma | |
| alt | permit. Pag Department Important; I any injury o once. | | 21. Signature of Fune 1 Servi License | • 4 | | | | | | | uneral Home |
| _ | 20 E 20 | | yau.M. | Dug | | 6401 Ridg | | | | ryland | 20872 |
| П | | | 23a. Part1. Er rt le disease, or complic shock, or hea t failure. List only on | cations that caused the deat e cause on each line. | h. Do not en | ter the mode of dyir | ng, such as cardia | c or respiratory ar | rest, | | Approximate Interval Between Onset and Death |
| 8 | Physician | | Immediate Cause (Final disease or condition resulting in de Mh) | - | 10110 | L | | | | | 2 days |
| | /Medical Examiner | | | Due to (or as a conseq | uence of): | | | | | | , |
| | | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a conseq | uence of): | | | | | | |
| | uted d ansit | Examiner | cause. Enter Underlying Cuase (Classes of hiju) that initiated events | | | | , | | | | |
| o, | the death certificate be executed y the attending physician and iched for use as the burial-transit | | resulting in death) Last | Due to (or as a conseq | uence of): | | | | | | |
| 8760, | ate be nysicia he bu | Physician/Medical | d | | | | | | | | |
| 9 | ing pt | Med | IF FEMALE: | | | | | | -1 | | |
| Box | eath certific attending p for use as t | ian/ | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcome pf pregn 1☐Live birth 2☐Feta | al death 3 | Ectopic pregnancy | y | | 23 | d. Date of deliv Month | ery Day Year |
| P.0. | he de the a | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant at time of a 9 ☐ Unknown | ieam 5L | Other (specify) _ | | | | | |
| | that the de ned by the a detached i | | Part II. Other significant conditions con | tributing to death but not res | ulting in the u | inderlying cause giv | ren in Part I. | 23e. Did to | bacco use | contribute to t | he cause of death? |
| sp. | The law requires that tte has been signed by page 2 should be deta | d by | Coronary he | art disea | 5.C | | | 1 🗆 \ | es 2X | No 3□ Pro | bably 4 □Unknown |
| Ç | w rec | Completed | Alzheimers | tupp d | em- | entia: | | 24a. Was | | 24b. Were auto | opsy findings available |
| Re | The lavate has | E G | 71121101110 | 10/ | | | | autop perfo 1□ Yes | rmed? 2 No | death? | impletion of cause of 2□ No |
| ital | | a | 25. Was case referred to medical | | | | 26. Place of Dea | ath (Check only o | | | |
| r < | Si iii | To B | examiner? | lospital: 1 Inpatient 2 | ER/Outpatie | nt 3□ DOA Oth | ier: 4 Nursing I | Home 5□ Resid | lence 6 | □Other (Speci | fy) |
| n o | ding Pi I. After ti funeral | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Wor | | 28d. Describe h | ow injury | occurred | |
| sio | Attending r death. ector: After by the fune | cati | Accident investigation 3 Suicide 6 Could not be | One Diese of injury. At h | ome form st | | Yes 2 □ No | 29f Location /6 | Stroot and | Number or Bu | al Route Number, |
| Division or Vital Records, | l or Attendatter death Director: | Certification: | 4 ☐ Homicide determined | 28e. Place of injury - At h building, etc. (Speci | fy) | reet, factory, office | | City or Tou | | IVUITIDET OF HUI | ar noute Number, |
| | To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | | | sician: To the best of my kn | | | | | | | |
| | the Hos hin 24 h the Fur npletely | edical | | ner: On the basis of examinand manner stated. | | | | | | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | | | 29c. Licens | A | | 29d. Date | signed (Month, | Day, Year) |
| | (2) | | 1 Rllen 01 3 | tarrelems | CRN | PROC | 56637 | / | 31- | 7/09 | |
| | (10) | | 30. Name and address of person who co | • | | | | | 14 | | - |
| | | | | RNP 3250 32. Registrar's Sign | Start | ing Gate | H Wo | odbine | ma | 1 217 | 47 |
| | St | ate | 31. Date filed (Month Day, Year) | no Dan riogistial s olgi | 1 | 1 | | | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Year **Physician** March 1,2009 3:30 AMM E. Dove Rebecca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Care & Rehab Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 F 92 214-05-2816 2/28/1917 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r items 23a or 28a-f shov ther must be notified at 28a-f shov MD 1 ☐ Yes 2X No Anne Arundel Crofton Directo permit. Pages 1 and 2 should be filed within 72 hours after death with the 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i any injury or other traumatic event, the Medical Exp. inter russt be routiful once. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21114 2131 Davidsonville Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes XXNo
If Yes, GiveXX 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White þ 3 Widowed 4 Divorced Year or Date Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary (92 condary (0-12) College() 1-4or 5+) Statistician Census Bureau 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dove James 0wen Mary Malone ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Dodon Road Davidsonville, MD 21035 Judith Elaine Dove Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 3/4/09 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Seption icensee 22. Name and Address of Facility 21401 Jan Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** 1Pan resulting in death) /Medical Due to (or as a consequence of) Examiner Sc. in it ally list controls if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and retely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 **N**0 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📈 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 √No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural
Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death are stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the within 2. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane Ste 222 Bowie, MD 20715 Dr. Rakesh Arora NAR 05 2009 Registrar's Signatu 31. Date filed (Month) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hy Year **Physician** 2:20AM Aloysius David Dady rebruain /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1⊠ M 2□ F 483-18-2026 Director 88 June 6, 1920 Iowa Usual Residence of Decedent 10c. City. Town or Location 10a State 10h. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination Director 1 TXYes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 12211 Fleming Lane 20715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify 3 ☐ Widowed 4 ☐ Divorced 1941-67 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working
life. DO NOT use retired) SMSGT, Officer College (1-4or 5+) U.S. Air Force Elementary/Secondary (0-12) of Special Investigations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Dady Christine Bartosh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carolyn G. Dady / Wife 12211 Fleming Lane Bowie, MD 20715 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/28/2009 | Baltimore, MD Bavview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service License Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Castric Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed?

1 □ Yes 2 □ No Hospital or Attending Physician: The certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural
2 Accident 1 □Yes 2 □ No 24 hours after death. Funeral Director: A etely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical npletely the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

042009

and manner stated.

2835 Smith Avenue Sw & 28 Baltimore MD 21205

29d. Date signed (Month, Day, Year)

Year)

29b. Signature and title of certifie

(Check only one)

32 Registrar's Signature

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

| | | | Please | Type or Prin | | | | | | | | • | | |
|----------|--|-------------------|---|---|-------------|---------------|--|--|--|---|-------------------------|---|--|--|
| | | | For State | State of Ma | aryland | | partmer <i>ertifica</i> | | | Mental Hy | giene | | | |
| - | | | Registrar 1. Decedent's Name (First, Middle, Later) | st) | | | - IIIICa | 16 01 1 | Dealli | 2. Date of De | Reg. No. | 2009 | 3. Hime of Beath 5 | |
| | Physicia /Medic | | James Alb | ert Elb | urn | | | | | March | | 2009 | 2320 PM | |
|) — | Examin Funeral | ner | Chester River Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | | | | | | 4b. City, Town, or Location of Death Chestertown If Under 1 Year If Under 24 Hrs. 8. Date of E Months Days Hours Min. (Month, I | | | 4c. County of Death Kent Birth Day, Year) 9. Birthplace (State or Foreign Country) | | |
| | Director | | Usual Residence of Decedent | M 2□F | 78 | Yrs | | Days | TIOUIS WIII. | 07/2 | | 930 | MD | |
| | Marylan -f show fied at | tor | MD 10b. County KENT | | | Town or | Location | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 X No | |
| : | th the | Director | 10e. Street and Number | | 1 | | 10f. Zi | p Code | | | 10g. Cit | izen of What Co | ountry? | |
| | 23a c | ral | 5827 S. HAWTHORN | | | | | 2166 | | | USA | | | |
| | items | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | S. 1 | I3. Was Dece If Yes, sp | edent of H ecify Cuba | lispanic Origin? (S an, Mexican, Puer | pecify Yes or No to Rican, etc.) | 0- | Race - Ame Black, White | | |
| 200 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Iniportant: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 1 ☐ Never Married | 1 XYes 2 ☐ I If Yes, Give Year or Dates: | | 1 | 1 ☐ Yes | | Specify: | | | | ITE | |
| 2 | "natı "natı | lete | 15. Decedent's Ed (Specify only highest gra | ducation ade completed) | | 16a. De (G | ecedent's Usi live kind of w le DO NOT i | ial Occup ork done i ise retired | ation during most of wo d) | rking | 16b. K | ind of Business | /Industry | |
| 717 | ed withi ygiene. er than t, the M | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | ERMAN | | | | | FOOD | | |
| 2 | be fill ntal H od oth even | Be | 17. Father's Name (First, Middle, Last | | | | | | 18. Mother's Nar | | | , | | |
| 2 | hould id Mer marke matic | 은 | WILLIAM EDWARD E | | | 19b. M | ailino Addres | s (Street | and Number or Ri | LBERTA | | | Zin Code) | |
| <u> </u> | nd 2 s alth an 27 is rtrau | | BONNIE L. USILTO | , | GHTER | 1 | | | | | - | | MD 21620 | |
| ָרָ ב | es 1 a of Hee Item | | 20a. Method of Disposition | 30 1/ 0: - | 20b. Pl | ace of Di | sposition (Na crematory or | me of | i | Date | | ocation - City or | | |
| | Page ment of ant: If ury or | | 1 X Buria! 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Specil</i> | | | - | CHAPE | | 3/11 | ./09 | ROC | K HALL, | MD | |
| חשוו | permit. Depart Import any Inj once, | | 21. Signature of Funeral Service Lice | nsee/ | | , | FELLOV | nd Addre | ss of Facility IELFENBEI | N & NEW | NAM | FUNERAL | HOME | |
| | Name of | | 23a. Part1. Enter the disease, or co | plication that caused | the death | . Do not | | | RD. CHES | | | 21620 | Approximate | |
| F | hysician | | shock, or heart failure. List only Immediate Cause (Final disease or condition | one cause on each III | | | 1 0 | La | mas 1 | li aca | | | Interval Between Onset and Death | |
| k. | /Medical | | resulting in death) | Due to (or as | a consequ | ence of): | a cu | mer | mus / | | | | 21010 | |
| | Examiner | <u>.</u> | Sequentially list conditions, | b | a consequ | ence of | | | | | | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 240 10 (01 43 | a oonloogs | orioc ciy. | | | | | | | | |
| ָר כ | executed an and rial-transit | | resulting in death) Last | Due to (or as | a consequ | ence of): | | | | | | | | |
| 00/00 | cate be physici the bu | dical | | d | | | | | | | | | | |
| א מם | certifi nding use as | /Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | | | | 23d. Date of de | livery | |
| 5 | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/Medical | in the past 12 months? 1 Yes 2 No 9 Unknown | 1 □Live birth 4 □Pregnant at 9 □ Unknown | | | 3 ☐Ectopic 5 ☐ Other (s | | y | | | Month | Day Year | |
| Ľ | s that ned by | by Ph | Part II. Other significant conditions | 0 | | | , , | • | | 23e. Did | tobacco i | use contribute t | o the cause of death? | |
| colds, | equire en sig ould b | ed b | 1 Slehydration | 2 mani | tion | (D) | Hypo | ens | ion | 1 🗆 | Yes 2 | DeNo 3□P | robably 4 Unknown | |
| 2 | law r nas be | Completed | | | | | | | | 24a. Was | psy | 24b. Were a | utopsy findings available completion of cause of | |
| ומו | : The cate t | Son | | | | | | | | perf 1∐ Yes | ormed? | death? 1 ☐ Yes | s 2□No | |
| = | siciar certifi rector | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | | | OA Oth | er _ | ath (Check only | | | | |
| 2 g : | a Phy er this eral di | 7: To | 27. Manner of Death | 1 Inpatie | ıry | 28b. Tim | | UA | 4 □ Nursing i | Home 5 ☐ Res 28d. Describe | | | ecify) | |
| 5 | ath. or: Aft | atio | | | | Inju | ime of 28c. Injury at york? M 1 ☐ Yes 2 ☐ No | | | | | | | |
| | after de after de I Directo d in by th | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death. To the Luneral Director, After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur | edical C | 29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa | nysician: To the best miner: On the basis o and manner st | of examina | wledge, d | leath occurre or investigation | d at the ti | me, date and plac opinion, death occ | e, and due to the urred at the time | e cause(s e, date an |) and manner a d place, and du | s stated. e to the cause(s) | |
| | To th Withir To th comp | Me | 29b. Signature and title of certifier | | | | 2 | | se number | | | te signed (Mon | th, Day, Year) | |
| ł | 12 | | 1 Lallle | n, MI | >_ | | | 0 | 21313 | | 3 | 11/09 | | |
| | + | | 30. Name and address of person who K, N K, WUN. 31. Date filed (Month, MA Par) | completed cause of d | leath (Item | 23a) (Ty | pe, Print) | 2, 0 | hestertor | wn, m | D. 2 | 1620 | | |
| | Sta | | 31. Date filed (Month, MAR) | 2009 32. Registr | ar's Signa | ture & | ha | 2 | | | _ | | | |
| | Regist | rar | ** * | The same | | Jo. | 1 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | 1 | | ertificate of Death | Reg. N | 2009 09036 | | | | | | |
|---------------------|---|---|---|--|---|---|--|--|--|--|--|--|
| ı | Physicia | ın | 1. Decedent's Name (First, Middle, Last) Beulah Josephine Erdheim | | | ay Year 2009 3. Time of Death | | | | | | |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | - | c. County of Death | | | | | | |
| عمر | | | 2409 Nees Ln 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | Silver Spring y) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year | Montgomery 9. Birthplace (State or Foreign | | | | | | |
| | Funeral Director | | 100-24-7591 1 | Months Days Hours Min. | Mar 19, 10 | | | | | | | |
| | /land | - | 10a. State 10b. County 10c. City, Town or | Location | | 10d. Inside City Limits | | | | | | |
| | e Mary Ha-fsh | Director | Maryland Montgomery Silver | Spring 10f. Zip Code | | 1 □Yes 2√□No | | | | | | |
| | vith the | | 10e. Street and Number | | | Citizen of What Country? | | | | | | |
| | eath v | Funeral | 2409 Nees Ln 11. Marital Status 12. Was Decedent Ever in U.S. 1. | 20905 3. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puertical Company of the Company | | JSA 14. Race - American Indian, | | | | | | |
| 92 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction must be notified a once. | y Fur | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No | 1 ☐ Yes 2 X No Specify: | o nican, etc.) | Black, White, etc. Specify: | | | | | | |
| 21215-0036 | hours | ed by | | cedent's Usual Occupation | | White Kind of Business/Industry | | | | | | |
| 215 | hin 72 e. an "na Medic | Completed | (Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+) | ve kind of work done during most of wor p. DO NOT use retired) | | | | | | | | |
| 121 | led wit fygien her th | S | | ocurement Analyst 18. Mother's Nan | ne (First, Middle, Maide | .S. Government en Surname) | | | | | | |
| and | d be fil ental H ced otl | o Be | 17. Father's Name (First, Middle, Last) William Brick | | Rosenbaum | | | | | | | |
| Baltimore, Maryland | should and Ma s mark | 2 | | ailing Address (Street and Number or Ru | ural Route Number, City | or Town, State, Zip Code) | | | | | | |
| Ž | and 2 | | Felice Erdheim/Daughter 240 | 9 Nees Ln. Silver | SPring, MD Date 20c. | 20905 Location - City or Town, State | | | | | | |
| Jore E | ages 1 nt of H ; If ite | | I 13X Rurial 2 I Cremation 3 I Hemoval from State I | sposition (Name of rematory or other place) | | , | | | | | | |
| Ħ | nit. Partme vartme cortant injury | | 4 □ Donation 5 □ Other (Specify) King Da 21. Signature of Funeral Service □ Cense | vid Mem Grdns Mar 22. Name and Address of Facility Hi | nes-Rinaldi | i Funeral Home | | | | | | |
| ă | Depared Important any in | | | | | ver SPring, MD 20904 | | | | | | |
| | Physician | | 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition) | | | | | | | | | |
| 1 | /Medical Examiner | | resulting in death) Due tr (o as a consequence of): | - Carliere | | | | | | | | |
| | | ř | Sequentially list conditions, if any, leading to immediate b. Due to (or as e consequence of): | 1 100000 | | | | | | | | |
|) | acuted ind transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c. | | | | | | | | | |
| 60, | tificate be executed ng physician and as the burial-transit | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| 68760, | ifficate g phys as the | edical | d | | | | | | | | | |
| Box | The law requires that the death cert ate has been signed by the attendin page 2 should be detached for use | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year | | | | | | |
| P.0 | d by the | Phys | 9 ☐ Unknown ' Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobacc | to use contribute to the cause of death? | | | | | | |
| ds, | uires the signer of the d | ρ | Tartii. Gilei Ggiintan Gallanda | | 1 ☐ Yes | 2 No 3 Probably 4 Unknown | | | | | | |
| of Vital Records, | law req nas beer 2 shou | Completed | | | 24a. Was an autopsy performed | 24b. Were autopsy findings available prior to completion of cause of death? | | | | | | |
| al B | | | | OS Pleas of Do | 1 □ Yes 2 eath (Check only one) | 1 ☐ Yes 2 ☐ No | | | | | | |
| Vit. | Physician: r this certific ral director, | o Be | 25. Was case referred to medical examiner? 1 Yes 220 No | Other: | Home Residence | e 6 Other (Specify) | | | | | | |
| | ng Phy fter thi neral o | on: To | 27. Manper of Death 28a. Date of Injury (Month, Day, Year) Inju | ry Work? | 28d. Describe how in | | | | | | | |
| Division | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 2 Accident investigation 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify) | M 1 ☐ Yes 2 ☐ No , street, factory, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| Ω | Hospital or 24 hours afte Funeral Dire stely filled in I | | 29a. Certifier (Chief only 2 Medical Examiner: On the best of my knowledge, only 2 Medical Examiner: On the basis of examination and/ | death occurred at the time, date and places investigation in my opinion death according to the control of the c | ce, and due to the caus | e(s) and manner as stated. | | | | | | |
| | To the Hos within 24 h To the Fus completely | Medical | and manner stated. | 29c. License number | | Date signed (Month, Day, Year) | | | | | | |
| | 10 5 ½ 6 9 | - | 29b. Spriature and title of certifier | 1808 | (| 3/Ld09 | | | | | | |
| | , ~ | | 30. Name and address of person who completed cause of death frem 23a) (Ty | Penny L. Bisl | gun Je | 0962 | | | | | | |
| - | St | ate | 31. Date filed (Month, Day, Year) MAR 0 9 2009 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Shirley Edwards 730P.M. [™] March 8 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bradford Oaks Nursing Home Prince George's

9. Birthplace (State or Foreign Country) Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. ^{Year)} 1927 1 □ M 2 ₩ F Months Hours 579 26 5631 81 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2√XNo MD Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 4568 Akron Street Unite States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X X Vo If Yes, Give 14. Race - American Indian, 1 Never Married 2 Married 1 □ Yes 2XXNo White If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RN Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Reed Davis Agnes Pearl Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Edwards (Husband) 4568 Akron Street, Temple Hills, MD 20748 March 18, 2003 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Maryland Veterans Cemetery Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Part 1. Enter the disease, or con shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2// Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 **100** 3 Probably 4 Unknown

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar attending physician for use as the buria signed by the a cate has been si page 2 should b this certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

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Completed

Be

Certification: To

Medical

Physician

Examiner

Director

Funeral

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Completed

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Physician

/Medical

Examiner

/Medical

| | | | | 24a. Was an autopsy performed? 1 ∐Yes ♣☐No | 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No | | | |
|--|--|--------------------------------|---|---|--|--|--|--|
| 25. Was case referred to medical | | | 26. Place of De | ath (Check only one) | | | | |
| examiner? 1 ☐ Yes 2 ☐ Vo | Hospital: 1 ☐ Inpatient 2 [| ☐ ER/Outpatient 3☐ | Home 5 ☐ Residence 6 | e 5 ☐ Residence 6 ☐ Other (Specify) | | | | |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury | occurred | | | |
| 3 Suicide 6 Could not be determined | | nome, farm, street, factorify) | ory, office | 28f. Location (Street and City or Town, State) | d Number or Rural Route Number, | | | |
| | Physician: To the best of my kraminer: On the basis of examinar and manner stated. | | | | and manner as stated. place, and due to the cause(s) | | | |

29b. Signature and title of certific

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frank Ryan, M.D., 11701 Livingston Road, #103, Fort Washington, MD 20744 31. Date filed (Month, Day, Year)

State Registrar MAR 0 9 2009

To the I within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09038 State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2009 1:01 A Claude Eikner March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 Union Hospital Elkton 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 X M 2 □ F 91 Apr. 29, 1917 New York Director 128-03-7022 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations is an utilied at once. 10a State 10b. County 1 ☐ Yes 2 X No Director Ceci1 Conowingo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 197 Johnson Rd. 21918 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 \overline{\overline{\text{No}}}\text{PS} 2 \overline{\text{No}}\text{No} \\
If \text{Yes, Give} \\
Year or \text{Dates: } 1943-46 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 0i1 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vester Eikner Lillian Smith ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Eikner/Wife 197 Johnson Rd., Conowingo, MD 20c. Location - City or Town, State Date 20a. Method of Disposition 03-11-2009 1 Burial 2 ☐ Cremation 3 ☐ Removal from State West Nottingham Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Colora, Maryland 22. Name end Address of Facility 21. Signature of Funeral Service License R.T. Foard Funeral Home, P.A. ech aro 111 S. Queen St., Rising Sun, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one car's so on each line. Immedi e Cause (Final Chronic **Physician** anh nown disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 刭 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 2 No 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ashder SMM 3.10.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Ellian MD21921 126 A E S.S SACHDEV MD 5×111 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

MAR 10

Please Type or Print in Black Indelibled nk/ Engyre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 09039 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** 1047 M **EVELYN EVANS** 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine WIOMICO TENINSUM REGIONAL SALISBUR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MAY 29, 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday, **Funeral** 1 □ M 2 🛛 F 90 DELAWARE 221-05-7191 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State 7 Is marked other than "natural", or Items 23a or 28a-f sho traumatic event, Ins Modical Examinar must be notified at 1 X Yes 2 □ No Director DELAWARE SUSSEX SELBYVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 19975 234 BAKER ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in the file and Mental Hygiene. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1∐Yes 2∭ZNo Specify. Specify: Š 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other fraumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OTTIS BAKER VIRA LONG ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SARALEE E. STEVENS/DAUGHTER 306 BAKER ROAD, SELBYVILLE, DELAWARE 19975 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State REDMEN'S CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 3/6/09 SELBYVILLE, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the down. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Bacteroides Fragilis Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as it consequence off Examiner burial-tran Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No P.0. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy After this certificate 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation s after dea. al Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who

Simona ENG

31. Date filed (Month, Day, Year)

SAlisbury, Md, 2180

Tise of death (Item 23a) (Type, Print)

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100 E. Corroll

| | | 1 | For State Registrar | | State of M | aryland | | rtment of H | | | | Reg. No | 00 | 09 | 090 | 40 |
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| | Physicia | | | ne (First, Middle, La | | | | | | | 2. Date of De Month | Dav Year | | | 3. Time of D | |
| ~ | /Medica | al - | | ELLIS FOX | | | | 4b. City, Town, or | Location | of Death | MARCH | 4c. County of Death | | | | |
|) | Examine | er ' | | RGNEC RD. | e street and number) | | | KENNEDYV | | | | KENT | | | | |
| <i>.</i> / | Funeral | | 5. Social Security I | Number 6.5 | Sex 7. Ag | ge (In yrs. las | t birthday) | If Under 1 Year Months Days | | r 24 Hrs. | 8. Date of Bir (Month, Da | th v. Year | | 9. Birthp | place (State or | Foreign |
| | Director | | 217-36-0 |)556 | 1 X M 2□ F | 89 | Yrs. | 9/4/1919 | | | | | | | PA | |
| | D > | - 1 | Usual Residence o | of Decedent 10b. County | | 10c. City. | Town or Lo | cation | | | | | | 1 | 0d. Inside City | Limits |
| | ith the Marylan or 28a-f show | | MD | KENT | | KENN | EDYVI | LLE | | | | | | | 1 □ Yes | 2 ∐ No |
| | the r | Director | 10e. Street and Nu | | | RELIT | | 10f. Zip Code | | | | 10g. C | itizen of W | hat Cour | ntry? | |
| | h with | a D | 29045 M | ORGNEC RI |) . | | | 2164 | 5 | | | | USA | | | |
| | ems ? | Funeral | 11. Marital Status | | 12. Was Decedent Armed Forces | ? | 13. \ | Vas Decedent of H f Yes, specify Cuba | ispanic C ın, Mexica | origin? (Spe an, Puerto | ecify Yes or No Rican, etc.) | D- | | e - Ameri k, White, | can Indian, etc. | |
| 0 | or it | by Fu | _ | ried 2 X Married 4 Divorced | 1 ∐Yes 2 [X] If Yes, Give Year or Dates: | No | | I∐Yes 2XNo | Specif | fy: | | | Specify | WH | ITE | |
| 0000 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Exent har must be notified at | | | | | | 16a. Dece | dent's Usual Occup | ation | | | 16b. k | Kind of Bu | siness/In | dustry | |
| 2 | hin 72 In "na Madik | Completed | (Spe | 15. Decedent's E ecify only highest gr | rade completed) College (1-4or | 5+) | (Give life. l | kind of work done of OO NOT use retired | during ma i) | ost of worki | ng | | | | | |
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| | should be filed within and Mental Hygiene. Is marked other than aumatic event, the Manatic event eve | Be | | e (First, Middle, Las | t) | | | | | ners Name NA KE | (First, Middle TCFD | e, iviaide | n Surnam | e) | | |
| Z Z | should be ind Mental marked o | 2 | | LEWIS FOX | (Time Drint) | | 10b Mailir | ng Address (Street | | | | ner City | or Town. | State. Zi | p Cade) | |
| = | d 2 sh th and 7 is n traun | | | Name/Relationship TH FOX/WI | | | | MORGNEC | | | | | | | ,, | |
| a, | ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. Tof ther zri is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marylori Exprime must be notified at | | 20a. Method of Di | | | 20b. Pla | | sition (Name of natory or other place | | | Date | , | | | own, State | |
| ē | Pages nent of ant: If its ary or o | | | 2 ☐ Cremation 3 l 5 ☐ Other (Spec | ☐ Removal from State ify) | 3 | PAUL' | | | 3/7/ | 09 | CHE | STER' | TOWN | , MD | |
| Baitimor | permit. Pages Department of Important: If it any injury or o | | | Funeral Service Lice | | 2 | 22 F F | Name and Addre CLLOWS, H O SPEER | ss of Fac ELFE | NBEIN | & NEWI | NAM MD | FUNER | RAL I | HOME | |
| | | | 23a. Part 1. Enter | r the disease, or co | mplications that couse | ed the death. | | | | | | | 210. | | Approximate Interval Bety | veen |
| , | Physician | 9 1 | shock, or he Immediate Cause disease or condit | e (Final | y one cause of each | Quer | xeMo | D | | | | | | | Onset and D | eath |
| | /Medical | | resulting in death | 1) | a. Duello (or a | s a conseque | | | - | | | | 855 | | | |
| | Examiner | | Sequentially list of | conditions, | b | b | | | | | | | | - | | _ |
| | ed sit | ıjne | Sequentially list of if any, leading to cause. Enter Und Cause (Disease) | immediate derlying or injury | Due to (or a | Due to (or as a consequence of): | | | | | | | | | | |
| | axecut and al-tran | Examiner | that initiated ever resulting in death | 11.5 | c Due to (or a | s a conseque | ence of): | | | | | | | | | |
| 58760, | death certificate be executed e attending physician and ed for use as the burfal-transit | edical E | | | d | | | | | | | | | | | |
| 89 | tificat ng phy as the | l edi | | | | | | - | | | | T | | | | |
| Вох | th cer tendir ir use | Physician/M | IF FEMALE: 23b. Was deceded in the past 1 | | 23c. If yes, outcom 1 ☐ Live birth | 2 Fetal | death 3 | Ectopic pregnanc | су | | | | | te of deli | | /ear |
| о. П | g o ō | sici | 1 ☐ Yes 2 | 2 □ No | 4 ☐ Pregnant 9 ☐ Unknowr | | ath 5 | Other (specify) _ | | - | | | | | | |
| <u>o.</u> | that the | | | | contributing to death | but not resul | ting in Ma | inderlying cause giv | en in Pa | rt I. | 23e. Did | tobacco | o use cont | ribute to | the cause of d | eath? |
| ds, | uires tha signed Id be det | d by | So | Jeres | Then | neus | XQ | monte | | | 10 |]Yes | 2 ∐ No | 3 ☐ Pro | obably 4 □ l | Jnknown |
| Record | w require s been signal | Completed | | | | | | | | | 24a. Wa | | 24b. | Were au | topsy findings | available |
| Re | hysician: The law his certificate has b I director, page 2 st | omp | | | | | | | | | per | opsy formed? 2 ☑1 | | death? 1 ∐Yes | ompletion of c | ause of |
| ta | ian: rtifica stor, p | Be C | 25. Was case re | ferred to medical | | | | | 26. Pla | ace of Dea | th (Check only | | | | | |
| <u>_</u> | Physic this ce al direc | | examiner? 1 ☐ Yes →2 | | | | | nt 3 🗆 DOA] | | Nursing H | ome 5 Re | | | | oify) | |
| ū | ding Ph h. After th funeral | ö | 27. Manner of De | 5 Pending | | njury Day, Year) | 28b. Time o Injury | Wo | iry at rk?]Yes 2 | □No | 28d. Describe | e now in | jury occur | rea | | |
| isio | death death stor: / | Icat | 2 ☐ Accident 3 ☐ Suicide | 6 ☐ Could not | to be a | niury - At hor | me, farm, st | | 1165 2 | | 28f. Location | (Street | a <i>nd Nu</i> mi | ber or Ru | rai Route Num | ber, |
| Division of Vital | after after Direct In by | ertification: To | 4 Homicide | e determine | building, | etc. (Specify | ') | reet, factory, office | | | City or T | own, Sta | ate) | | | |
| _ | spital | O | 29a. Certifier | 1 Certifying | Physician: To the be aminer: On the basis | st of my know | wledge, dea | th occurred at the | time, date | e and place | , and due to the | ne cause | e(s) and m | anner as | s stated. | 3) |
| | To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | Medical | (Check only one) | | aminer: On the basis | stated. | and/of l | | | | | | | | | |
| | To the To the Com | Σ | 29b. Signature a | indititle of certifie | n G | | | 29c. Licen | | | 61 | 29d. I | 2 C | | h, Day, Year) 2 | |
| | 3 | | P | Alula | end 4 | | 00-1 (= | | | 608 | | | 0 13 | v. | _ | |
| | 14.0 | | 30. Name and | doress of person | no completed cause | death (Item | (Type | 122 SK | MS | KD | SPE | 5 | Cette | 1512 | More, | who |
| | ivi s St | ate | 31. Date filed (N | Nonth Day Year) | 7.00 | strar's Signat | ture | had? | | | | | | | | |
| | Regist | | | MAR 1 0 | ZUUS A | were a | P. A | Person | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09041 Reg. No.2 0 0 9 Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) FLETCHER 5:15 P DONNA FEBRUARY 24 2009 LEE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) KENT CHESTERTOWN 7824 COUNTRY CLUB LANE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/27/1959 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 💢 F 49 NJ 216-78-7740 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No CHESTERTOWN KENT 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21620 USA 7824 COUNTRY CLUB LANE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPTROLLER AUTOMOTIVE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PATRICIA RENSHAW ROYAL T. LOCHTEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7824 COUNTRY CLUB LANE CHESTERTOWN, MD 21620 LEONARD FLETCHER/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) PAUL'S 2/27/09 CHESTERTOWN, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee complications the coased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only on cause on each line. 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) ATEREST CARDIO PULLURUM Due to (or as a consequence of) axeruoun to PANiess He tAS MATOC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ■ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐Yes 2 ₩ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Physician /Medical **Examiner** and

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination into the profiled at once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

/Medical

burial-trar attending physician for use as the buria cate has been signed by the page 2 should be detached director. After

Hospital or Attending Physician: The law requires that the death certificate be executed

Examine Physician/Medical ģ Completed Be Medical Certification: To

n 24 hours after death.

e Funeral Director: A letely filled in by the fu

| 2010010 | within 24 ho | To the Fun | completely | |
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| | | 8 |) | |

State Registrar 5 Pending investigation

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

223 RIZABAL

Street, CHESteptown, Med. 21620.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day **Physician** 2 2009 3:08 p Wood Forte Betsy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ocean City 7301 Atlantic Ave. Unit 3B Worcester 5. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F 74 477-36-3790 8/21/1934 Director VΑ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Malical Evandam Trust be 14 Illied at 1X Yes 2 No Director MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Medical Event incorrust bean any injury or other traumatic event, the Medical Event incorrust bean and once. 21842 USA 7301 Atlantic Ave. Unit 3B Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status rmed Forces? 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Relations Owner/Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garland Morris George W. Hillsman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Conneticut Ave NW, Washington DC 20008 - 2205 William A. Forte / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 3/3/2009 Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an performed? 1 □ Yes 2 ☑ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed thours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760, 24 hours a

28a-f show

the

Saltimore, Maryland 21215-0036

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To the within 2.

State Registrar

completely

Medical

VanVorhees, Lucy 31. Date filed (Month, Day, Year) MAR U5

29a. Certifier

(Check only

29b Signature and title of certifier



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Berlin, MD 21811

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month 10:02 P M March 3, 2009 Foss Nancy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charles Civista Medical Center La Plata If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month Day,
Aug. 1, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**X**□ F 78 Pennsýlvania 186-22-9075 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12113 Bretwood Court U.S.A. 20602 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X☐ No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Office Office Manager 18. Mother's Name (First, Middle, Maiden Surname) Frank Patterson Mildred Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12113 Bretwood Court, Waldorf, Maryland, 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland 3035 ud Walkeytus Rd 03/09/2009 Huntt Crematory Waldert, ML 2461 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Physician/Medical Examine

Completed

Be

Medical Certification: To

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show

permit. Pages Department of Important: If it any injury or or

Physician

Examiner

/Medical

signed by the a

certificate

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantres must be notified at

Craig Foss/Son 20a. Method of Disposition

21. Signature of Funeral Service Licenses

Immediate Cause (Final resulting in death)

Schemi Due to (or as a consequence of): Hispertension Due to was a consequence of) Due to (or as a consequence of):

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |
|--|
| |

| Bb. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl 9 ☐ Unknown |
|--|---|
| 9 Unknown | |

Live birth 2 Fetal death Pregnant at time of death 5 Other (specify)

23d. Date of delivery 3 🗆 Ectopic pregnancy

26. Place of Death (Check only one)

IE EEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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|-----|-------------|------------|-------------------|----------------|
| | 1 🗆 Yes | | 3 ☐ Probably | |
| 230 | . Did tobac | co use con | indute to the cat | ise of dealif? |

Month

Day

Year

vivere autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2 🗖 No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 27. Manner of Death 1. Alatural

5 ☐ Pending investigation

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 🗌 Suicide 4 Homicide 29a. Certifier

2 Accident

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier M. Jagouri MD

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tagour. M.D 25500pointro-contrad. Leantown, MD 20650

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Box 68760. 0 ۵. Records, Division of Vital

the death certificate be executed the attending physician and ned for use as the burial-transit

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ 1300 hrs March 6, 2009 Medical Examiner Anola Fenwick Vanessa 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min 04/06/1952 Country) Wash.,DC 56 Director 578 70 4155 M 2X F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location any 10a, State 10b. County X Yes 2 No Washington DC 28a-f show once. hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at 20019 US 3668 Hayes Street NE #201 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status þé If Yes. specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married XNo Yes 0 Black Yes 2 X No specify: Specify: Yes. Give Year Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 l Oppart: rent of He-t/th and Mental Hygiene. Important: If item 27 is mer'ed other than " Federal Government mer'ed other than " Custodian Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Robinson James Francis Fenwick Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yolanda Fenwick Brown/daughter 8951 Town Center Circle #107 Largo, MD 20774 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 t: If it Cremation 3 Removal from State Washington Nat'l Cem 3-13-2009 Suitland, MD Donation 5 Other Specify: 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME PA ortature of Funeral Service Licensee Models 2294 Old Washington Road Waldorf, MD 20601 iscee ou Approximate Interval Part I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List one cause on each line. /Medical Death a. Complications of Chronic Alcohol Use Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Fineral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown ş Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 1 1 No 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital: 1 / Inpatient Other Residence 6 DOA Nursing Home 5 1 VYes ٩ 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 To the I and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier March 8, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (Month, Day, Ye 32. Registrar's Signature State arks

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Elizabeth Finney 4:00 AM Goldia -2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3+. Thomas Moore Nursing Home HYOHSVIlle Prince 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 231-30-3849 1 M 2 F 9 Days Hours Min Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 28a-f show Washington DC 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? +h Place SE 20032 U50 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 Who If Yes, Give Year or Dates: 1 Never Married 2 Married Blac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Guard Private becurity ノスナガ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Lee Dennis walter Golden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 702 Painters Ct capital Heights, mp 20743 Leland Finney 30N 20a. Method of Disposition
1 ☐ Burial 22 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Riverdale Park Crem 03-07-09 Riverdale, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bianchi 814 Upshur St NW Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mening oma Due to (or as a consequence of): **Physician** y exus /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Infury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cersualowaThi 24a. Was an autopsy performe rmed2 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DF MS4203 Queensbury Rd Hyattsville MD 20181 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back Registrar

DHMH 17 Rev 1/2001

ORIGINAL

| 09-02001 Mark David Forney | у | Ple | | | Print in E f Maryland | I / Depar | rtmen | t of He | alth an | | | | gible | 20 | 09 | 0904 |
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| Sec. 1970 | 13 | - For State legistrar | (F: . Nr.) | | | Cert | tificate | of De | ath | | To F | | eg. No. | | 3. Time | of Dooth |
| Physician Medical Examine | er | 1. Decedent's Nam | k D | • | Forney | | | 14.0 | | | M | Date of Dea Month Jarch 10, | Day 2009 | Year County of Dea | 1537 | 7 hrs |
| | | 4a. Facility Name (i 501 Clyde A | | on, give s | street and numbe | er) | | | iy, rown, oi uitland | r Location of | Death | | - 1 | Vicomico | iu i | |
| Funeral Director | L | 5. Social Security N 217–54–7 | 272 | 6. Sex | 7. A | Age (In yrs. Ia | st birthda | | Inder 1 Yea | | I Min | | 9. Birth (MM/DD/YYYY) Foreign 1/1958 Refy | | | |
| any | _ | Usual Residence o 10a. State | f Decedent 10b. County | | | 10c. City, | Town or I | Location | | | | | | | 10d. Ins | ide City Limits |
| ≥ | ١ | Maryland | | mico | | | Frui | tland | | | | | - 11 | | es 2 No | |
| the Maryland or 28a-f show officed at once | 2 | 10e. Street and Nu 501 | mber Clyde | Ave. | | | | 10f. | Zip Code 2182 | 26 | | | log. Citi: | zen of What Co USA | ountry? | |
| S 72 hours after death with the Maryland n "martural", or items 23n or 28a-f she nd Examiner must be notified at once | Funeral | 11. Marital Status 1 X Never Marri | | larried | 12. Was Decede Armed Force 1 Yes | | S. 1: | If Yes, sp | ecify Cuba | ispanic Origii ın, Mexican, I | | | 0- | White, etc. | Race - American Indian, Black, White, etc. | |
| rs after ural", miner | ᆰ | 3 Widowed 15. Decedent's E | | | Yes, Give Year or Dates: highest grade c | ompleted) | 16a. De | | | o specify: ation (Give ki | ind of work | done | 16b. h | Specify: Kind of Busines | white | |
| 36 hin 72 hou e. than "nati edical Exa | Completed | Elementary/Sec | | | College (1-4 o | | dur | | working life | e. DO NOT u | | | | | | nt repai |
| 215-0036 he filed within mulal Hygiene. rked other tha fent, the Medic | | 17. Father's Name Ralph | | | | | | | | 18.Mother's | Name (Fir | | | | атрис | ic repair |
| imore, MD 21215-0036 Pages I and 2 should he filed within 72 hours after death with the Maryland ment of Health and Mental Hygener, from 27 is marked other than "natural", or items 23n or 28n-f sho or other transmatic event, the Medical Examiner must be notified at once. | To Be | 19a. Informant's Na Jean F | ame/Relations | ship (Typ | | | | • | , | eet and Numb | per or Rura | l Route Nu | | ity or Town, Sta | | e) |
| and 2 she featth and 2 tem 27 is | + | 20a. Method of Dis | | | | | Place of D | Disposition | Name of co | | | ate | | Location - City | | ate |
| | | Salisbury Crematory 3/13/09 Salisbury Cremat | | | | | | | | | | | | | | |
| Balt permit Depart Impor injury | 1 | 77. Sic nature of Fi | Se Se | ICE | ee · | | | ²² H81 501 | Toway Snow | Fune Hill | ral Ho Rd., | ome P Sali | rofe sbur | essiona cv, MD | l Asso 21804 | ociatio |
| Physician /Medical | 4 | failure. List or | nly one cause | e or Lac | tions that caus line. Atheros | | | enter the mo | ode of dying | g, such as ca | irdiac or res | spiratory ar | rest, sh | ock, or heart | Appro | ximate Interval een Onset and Death |
| xaminer | | Immediate Cause or condition result | ing in death) | _ | ue to (or as a co | | | Larur | Jvasci | urar u | Iseas | | - 50 | | | |
| | <u>ne</u> | Sequentially list co if any, leading to it cause. Enter Und | mmediate | | ue to (or as a co | nsequence of | f): | | | | | | | | | |
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| oe executician and | dical | X |) | | AMENDED | 23a,27 | ,pei | rME, { | 3889 | 3/24/0 | 9 TT | | | - | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | | IF FEMALE: 23b. Was deceden past 12 month | s? | | 23c. If yes, out 1 Live birth 4 Pregnant | | 2 | Fetal de | eath 3 (Specify) | Ectopic | pregnancy | , | 23 | d. Date of deliving Month | very Day | Year |
| O. Bo. It the deat by the at ached for | 훕 | Part II. Other sign | | itions | 9 Unknown | | esulting in | n the under | lying cause | e given in Pa | rt I. | 23e. Did | tobacco | use contribute | to the caus | e of death? |
| ords, P.O. w requires that the seen signed by should be detact | ğ | | | | | | | | | | | | | No 3 F | | |
| Division of Vital Records, tal or Attending Physician: The law requirn staffer death all Director: After this certificate has been sited in by the funeral director, page 2 should be a bound to be the funeral director, page 2 should be a should be | Completed | | | | | - | | | | | | 24a. Was auto perf 1 Yes | opsy ormed? | | to completion? | dings available on of cause of |
| ital Re(ician: The sertificate | Be C | 25. Was case refe examiner? | rred to medic | - | ospital: | | | - | | ce of Death (| 1 | H- | 1 | | | |
| of Vifiing Physic | ္ | 1 Yes 27. Manner of Dea | 2 No | | 28a. Date of | atient 2 | | me of Injury | DOA 28c. In | jury at Work | Nursing H | | | ence 6 🗸 O | ther: Scene | _ |
| ion of tending Ph eath or: After t | tion | 1 X Natural | 5 Per | nding | (Month, Da | ay,Year) | | | | Yes 2 | | | | | | |
| Division Hospital or Attent 24 hours after death Funeral Directors stely filled in by the | Certification: | 2 Accident 3 Suicide 4 Homicide | determined (Specific) | | | | | | | | | | e Number, City | | | |
| To the Hospital within 24 hours To the Funeral completely filled | Medical C | 29a. Certifier 1 (Check only one) 2 | Certifying I | aminer: | n: To the best of on the basis of on and manner state | examination a | ge, death and/or inv | occurred a | at the time, in my opini | date and pla on, death oc | ice, and du- curred at th | e to the cau ie time, dat | use(s) a e and pl | nd manner as s lace, and due t | stated. the cause | (s) |
| To To Sign | Me | 29b. Signature an | d title of certif | | and manner state | | | | i | nse number | - | _ | | Date signed (| | Year) |
| | | Panale | of Vour | hall | MA | of death /lice | 330) | _ | 0.0 | C.M.E. | _ | | Ma | rch 11, 200 | 9 | |
| | | 30. Name and add | | | Assistant M | | miner | | | et, Baltim | ore, MD | 21201 | | | | |
| Sta | ate | 31. Date filed (Mo | nth, Day, Year | 6 20 | 32. egis | strar's Signati | Ø. , | bank | | | | | | | | |

amend line 10e per fd aco hlth deptrate / 05/09 dlw

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

09047

| | | | Registrar | | | | | | | r | ey. No. | | | | |
|--------------------------------|--|---------------------|---|--------------------------------------|--|---------------------|--------------|---|--|---------------------------------|---------------------------------|--------------------|---|----------------------|--|
| Physician /Medical | | | 1. Decedent's Name (First, Middle, Last) James David | | | | | Finn | | 2. Date of Dea Month 03 | 02 Day | 2009 | 3. Time of 0741 | Death M | |
| - | Examin | | 4a. Facility Name (If not in | , , | | | | , | r Location of Deat | | 4c. C | County of Death | | | |
| 1 | | | Holy Cross | _ | | (In one look | hinth days | Silver | Iontgomery 9. Birthplace (State or Foreign | | | | | | |
| | Funeral Director | | 5. Social Security Numbe 277-40-9267 Usual Residence of Dece | 11/2 | / 2□ F | (In yrs. last | Yrs. | Months Days | Hours Min. | | / Year) 944 | _Co. | xas | - Oreign | |
| | land ow | | | County | | 10c. City, To | own or Lo | ation | | | | | 10d. Inside Cit | y Limits | |
| | a-f sh | ctor | MD Mo | ntgomery | | Sil | lver | Spring | | | | | 1 🗆 Yes | 2 □No | |
| | or 28 | Dire | 10e. Street and Number | | | Road | | 10f. Zip Code | | | 10g. Citizen of What Country? | | | | |
| | ath w | ral | | Bradock | | | | 2090 | |) N N | USA 14. Race - American Indian, | | | | |
| 36 | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Mydical Evan The Traillish at or other traumatic event, the Mydical Evan The Traillish at | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ □ | Married | . Was Decedent E Armed Forces? 1∭Yes 2 ☐ N If Yes, Give Year or Dates: | | 5 | Yes, specify Cubi | Hispanic Origin? (S an, Mexican, Puer Specify: | to Rican, etc.) | | Black, White | | | |
| 2-0 | '2 hou | ted | 15. [| Decedent's Educa Decedent's Educa | tion | 1 | 6a. Deced | lent's Usual Occup | pation during most of wo | rking | 16b. Kin | d of Business/I | Industry | | |
| Baltimore, Maryland 21215-0036 | d within 7 giene. er than "n | Completed | Elementary/Secondary | | College (1-4or 5- | +) | life. L | FO | d) | King | E | Energy | | | |
| pu | tal Hy | Be | 17. Father's Name (First, | | | | | | | me (First, Middle, | Maiden S | Gurname) | | | |
| yla | ould to | ဥ | James | | | | | | Elizabet | | | | | | |
| Mar | d 2 sh th and 7 is m traum | | 19a. Informant's Name/F Jan Finn | | . Print) Spouse | 1 | | | Road Si | | | | | | |
| <u>6</u> | permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once. | | 20a. Method of Disposition | on | | 20b. Plac | e of Dispos | sition (Name of | 1 | Date | | ation - City or | | | |
| m 0 | Pages ient of nt: If i | | 1 ☐ Burial 2XXCre 4 ☐ Donation 5 ☐ | | noval from State | | | natory or other place Cremator | | /09 | Glen | Burni | e,MD | | |
| alti | Departm Departm Importa any inju | | 21. Signature of Funeral | | | | | . Name and Addre | | | 21401 | | | | |
| <u>m</u> | 89 = 89 | | 13 g. | Jun | | | H | ardesty l | Funeral I | Home P.A. | . 12 | Ridgel: | • | - | |
| | | | 23a. Part 1. Enter the dis shock, or heart fail | ure. List only one | tions that caused cause on each lin | the death. [le. | Do not ent | er the mode of dyi | ng, such as cardia | c or respiratory ar | rest, | | Approximate Interval Betw Onset and D | veen)eath | |
| - | Physiclan /Medical | Ì | Immediate Cause (Final disease or condition resulting in death) | a. | | | | nfarction | n | | | | | | |
| 7 | Examiner | | , | | Due to (or as a | a consequen | ice of): | | | | | | | | |
| | | Jer | Sequentially list condition if any, leading to immedia Cause (Disease or injury | ns, b. | Due to (or as a | a consequen | nce of): | | | | | | | | |
| | cuted nd ransit | Examiner | that initiated events | с. | | | | | | | | | | | |
| 30, | oe exe cian a urial-t | | resulting in death) Last | | Due to (or as a | a consequen | ice of): | | | | | | | | |
| 68760, | th certificate be executed tending physician and r use as the burial-transit | an/Medical | | d. | | | | | | | | | | | |
| ox 6 | certifi nding ise as | /Me | IF FEMALE: | 23 | . If yes, outcome | of pregnancy | у | | | | 2: | 3d. Date of deli | iverv | | |
| . Bo | death a atter d for u | iciar | 23b. Was decedent preg in the past 12 mont 1 □Yes 2 □ No | 10 | 4 Pregnant at | | | Ectopic pregnand Other <i>(sp</i> ec <i>ify)</i> _ | cy | | | Month | | ear/ | |
| P.0. | w requires that the death s been signed by the atte should be detached for | Physici | 9 □ Unknown | | 9 Unknown | | | | | | | | | | |
| _ | es tha igned be del | | Part II. Other significant | conditions contr | ibuting to death bu | ut not resultin | ng in the ur | nderlying cause glv | ven in Part I. | | | | the cause of de | | |
| Division of Vital Records, | een s | Completed by | | | | | | | | 1 L Y | ′es 2∟ |]No 3□ Pr | | Jnknown | |
| Sec. | ha: 62 | nple | | | | | | | | 24a. Was autop | sv | 24b. Were au | topsy findings a completion of ca | available ause of | |
| a F | Th ate pag | | | | | | | | | perfo | | death? 1 □ Ye s | 2 🗆 No | | |
| V. | Physician: r this certific ral director, I | Be | 25. Was case referred to examiner? 1 ☐ Yes 2 ☐XNo | | spital: | | | Ott | | ath (Check only or | | T011 12 | -:-: | | |
| of | Physer this eral di | 15 | | | 28a. Date of Injui (Month, Day | | 3b. Time of | | her: 4 □ Nursing I iry_at | dome 5 ☐ Resid | | | cify) | | |
| ion | nding tth. :: Afte e fune | tior | 27. Manner of Death 1 □ Natural 5 [2 □ Accident | ☐Pending investigation | (Month, Day | v, Year) | Injury | | rk?]Yes 2 □ No | | | | | | |
| visi | Atter | ifica | | Could not be determined | 28e. Place of Injubuilding, etc. | ury - At home | e, farm, str | eet, factory, office | | 28f. Location (S City or Tow | Street and | Number or Ru | ıral Route Numi | ber, | |
| ۵ | tal or | Certification: To | Tiomicide | | ballaling, etc | o. (opcomy) | | | | Only or Ton | m, otato, | * ** | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | | | cian: To the best of er: On the basis of and manner sta | f examination | | | | | | | |) | |
| | To the To the Comp | M | 29b. Signature and title of | of certifier | 1 , | MI |) | 29c. Licens | se number | - | 29d. Date | signed (Monti | | | |
| | 1. | 5 | Dani | dx. d | ech ! | 111 | | 1)0 | 06 1213 | | 3/2 | 12001 | , | | |
| | (A) (B) | X . | 30. Name and address of Daniel Ken: | | | | | | Road Silv | ver Sprin | / ng,MD | 20910 | | | |
| | Sta | | 31. Date filed (Month, Da | | | ar's Signature | par | N. S | | | | | | | |
| | Regist | rar | MAR | 0 5 2009 | anna | p. | your | 100 | | | | | | | |

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

show

items 23a or 28a-f shor

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

δ

Completed

Be

2

/Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, I = M once. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Signification in the state of t Examine burial-trai attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant in the past 12 months? certificate has been signed by the irector, page 2 should be detached 9 XUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Be Completed 25. Was case referred to medical examiner? 1 Yes 2 X No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes after death Director: 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i 24 hours af e Funeral D fetely filled in 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 ho

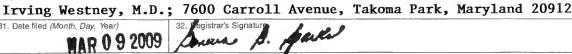
To the Function

completely 1 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2 48683 March 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State MAR 0 9 2009



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** P^{M} James Norman Gregg March 5. 2009 2:10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 01ney Montgomery General Hosptial Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Months Days Hours 1 🕅 M 2 🗆 F 15, 1923 Washington, DC Director 217-36-7686 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City. Town or Location 28a-f show tems 23a or 28a-f sho 1 ☐ Yes 2 X No Director Mount Airy Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 USA 26150 Mullinix Mill Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or items 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. Specify: 2 3 X Widowed 4 ☐ Divorced White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Contractor 9 Electrician permit. Pages 1 and 2 should be file.
Department of Health and Mental HyoImportant: If item 27 is markany injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy James Tapp ဥ Norman Wesley Gregg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3659 Petersville Road, Knoxville, Maryland 21758 Helen Louise Houck, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Tabor Cemetery 3/9/2009 Laytonsville, Maryland 4 ☐ Donation □Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge ROad, Damscus, Maryland 20872 23a. Part 1. Epit the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in high art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in Teath Physician Kenocarcinoma /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, seymong IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death
9 Unknown 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an cate has t page 2 sl Chem autopsy performed? certificate 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director; After this certificaletely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

back

and address of person who completed cause of death (Item 23a) (Type, Print)

MUEVA,

BABEL

Year)

09

2009

MARLA

31. Date filed (Month, Day,

| 09-02078 Raymond Gregg | Please Type or Print in Black Indelible State of Maryland / Department | | _ |
|--|--|---|--|
| Traymond Oregg | 1- For State Certificate | of Death Reg | 2009 0905 |
| Physician/ Medical Examine | / . / | 2. Date of Death Month March 13, 2 | Day Year 2107 hrs |
| 1 | 4a. Facility Name (if not institution, give street and number) 403 Lake Street | 4b. City, Town, or Location of Death Salisbury | 4c. County of Death Wicomico |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) |). If Under 1 Year If Under 24Hrs. 8. Date of Birth | n(MM/DD/YYYY) 9. Birthplace (State or |
| Director | 531-06-311812 - 63 | Yrs. Months Days Hours Min. 5-5-1 | C145 Foreign Country) S. Carclina |
| B CONTRACTOR OF A CONTRACTOR O | Usual Residence of Decedent 10a. State | cation | 10d. Inside City Limits |
| Maryland 28a-f show d at once. | 10e. Street and Number | Ugh 4 10f. Zip Code 10 | g. Citizen of What Country? |
| the Maryland as or 28a-f shufified at once | 423 Lake Street | 21801 | USA |
| or items 23a or 28a-f sho | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. | Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14, Race - American Indian, Black, White, etc. |
| ē : ' b | 1 3 Midowed 4 Divorced II Tes. Give Teal | Yes 2 No specify: | Specify: Black |
| hours hours Exam | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | edent's Usual Occupation (Give kind of work done ig most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| 15-0036 filed within 72 hours at 14/yeiene. ed other than "natural, the Medical Examin e. Completed by | Elementary/Secondary (0-12) College (1-4 or 5+) | Group Leader | Hospital |
| 15-0 filed will Hygie and other | | 18. Mother's Name (First, Middle, M | |
| nore, MD 21211, signs 1 and 2 should be fill not of Health and Mental Fit: If item 27 is marked other traumatic event, To Be | 19a. Informant's Name/Relationship (Type, Print) (Will 19b. Ma | ailing Address (Street and Number or Rural Route Number | ber, City or Town, State, Zip Code) |
| e, MD I and 2 sho Health and item 27 is | Valerie Ann Gregg 140 | 3 Lake Street, Scalisba | 20c. Location - City or Town, State |
| more, Pages I an nent of Hea ant: If itea | 1 Burial 2 Cremation 3 Removal from State crematory o | or other place) Hhaus (Posselvy 3-32-3609) | Laurel De |
| Baltime permit: Pag Department Important | Donatal Care Care | 22. Name and Address of Facility | 1 W. Isabella Street |
| Physician | 23a. Part I. Enter the disease, or complications that caused the death. Do not ent | ter the mode of dying, such as cardiac or respiratory arre | ist, shock, othern Approximate Interval |
| /Medical xaminer | | rosclerotic cardiovascula | Between Onset and Death |
| \smile | or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. | | |
| iner | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | |
| ecuted and transit transit | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | |
| | | perM,E g889 3/26/09 TT | |
| ox 68760, auth certificate be exception of the control of the cont | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 | Fetal death 3 Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| Box 687 Box edath certifice the attending ped for use as the | 4 Pregnant at time of death 5 | Other (Specify) | |
| P.O. Bost the degree of the de | | | bacco use contribute to the cause of death? 2 No 3 Probably 4 ✔ Unknown |
| of Vital Records, P.C g Physician: The law requires that after this certificate has been signed the metal director, page 2 should be detain. To Re Commileted by | | 24a. Was a | an 24b. Were autopsy findings available |
| Records, The law require: ficate has been sig. page 2 should be | | autop: perfor | med? death? |
| Vital Rec ysician: The his certificate director, page | 25. Was case referred to medical | 26.Place of Death (Check only one) | |
| n of Vid ting Physic After this a | 1 V Yes 2 No inpatient 2 ER/Outpat | | Residence 6 🗸 Other: Scene |
| ion c tending eath. for: Af the fun | 1 X Natural 5 Pending (Month, Day,Year) 2 Accident Investigation | 1 Yes 2 No | |
| Division o Spital or Attending spital or Attending nours after death neral Director: After filled in by the fune Contification: | 3 Suicide 6 Could not be determined (Specify) | street, factory, office building, etc. 28f. Location (S or Town, S | Street and Number or Rural Route Number, City tate) |
| | | occurred at the time, date and place, and due to the caus | e(s) and manner as stated. |
| To the Ho within 24 roothe Ho completely | 2 wedical Examination and an anner stated. 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | Carol Hallan | O.C.M.E. | March 14, 2009 |
| | 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Per | nn Street, Baltimore, MD 21201 | |
| Stat | e 31. Date filed (Month, Day, Year) 32. Kegistrar's Signature | barles | |
| Registra | PIAR TO CHAR | | |

DHMH 17 Rev 1/2001 OCME 2006

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Registrar

MAR

DOME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year CHARLES LUTHER HALL 1325 P FEBRUARY 23, 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR CHESTERTOWN KENT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Min. 1 X M 2 □ F Director 190-14-9470 12/31/1923 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shoi traumatic event, the Medical Eventhar in ust be mutified at Director MD KENT CHESTERTOWN 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 101 MORGNEC RD. APT. E-102 21620 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired)

DIRECTORATE OF MATERIAL TESTING Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, In 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ SCOTT LEVI HALL OLIVIA MARY HUNT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES HALL/ WIFE 101 MORGNEC RD. APT E-102 CHESTERTOWN, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STILL POND CEM. 2/28/09 STILL POND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Such 23a. Part 1. Enter the disease, of compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician plan disease or condition resulting in death) ance /Medical Due to (or as a consequence of): Examiner meterle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 5 ☐ Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe or Attending Physician: The 2 □No 2 1 NATO 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Universing Home 5 Residence 6 Other (Specify, Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Tyes 2 🗆 No within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month.

Vash

Chestertown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 09053

| | | 1- For State Certificate of Death Reg. No. | | | | | | | | | | | | | | |
|---|---------------|---|--------------------|--|------------------|----------|----------------|------------|-------------|--------------|-----------------------|----------------|---------------|-------------------|---|--|
| Physicia | | Decedent's Name (First, Middl | e,Last) | | | | | | | 2 | . Date of De Month | ath Day | Year | 3 | 3. Time of Death | |
| edical Exami | ner | Rozeeta Ann H | olley | | | | | | | | February | 28, 20 | 009 | | 0104 hrs | |
| | | 4a. Facility Name (if not institutio | | number) | | 41 | b. City, Tow | n, or Lo | cation of I | Death | | | . County of I | | | |
| | | 4109 53rd Place | | | | | Bladens | burg | | | |] P | rince Ge | orge's | ; | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In y | rs. last birthda | ay) | If Under 1 | If Under 2 | 24Hrs. | 8. Date of B | irth (MM/ | DD/YYYY) | 9. Birthr | place (State or | | |
| Director | | 220-19-4030 | | | 23 | | Months | Days | Hours | Min. | Novemb | ~ 22 | 1005 | Foreign Coun | Washington, | |
| Director | | | 1 M 2 X | F | | Yrs. | | | | er 23 | ,1900 | | ntry) DC | | | |
| | 1 | Usual Residence of Decedent | | 1100 (| City, Town or | Logotic | | | | | | | | 1 | 10d. Inside City Limits | |
| a au | | 10a. State 10b. County | _ | | • | | | | | | | | | | 1 X Yes 2 No | |
| shor | 5 | Maryland Prince | e George | 's BI | adensb | urg | 5 | | | | | | | | | |
| Maryland 28a-f show any d at once | 호 | 10e. Street and Number | | | | | 10f. Zip Co | ode | | | | 10g. Citi | zen of What | t Countr | γ? | |
| he N iffed | Director | 4109 53rd Pla | ce | | | | 2 | 071 | 0 | | | US. | A | | | |
| with the Maryland ms 23a or 28a-f sho be notified at once | | 11. Marital Status | 12. Was | Decedent Ever | n U.S. 1 | 3. Was | s Decedent | of Hispa | nic Origin | n? (Spe | cify Yes or N | 0- | | | an Indian, Black, | |
| eath v item | Funeral | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 X No specify: | | | | | | | | | | | | | | |
| er de | | | | | | | | | | | | | 3ira | cial | | |
| rs afi ural' | þ | 15. Decedent's Education (Spe | or Dates: | | d) 16a. De | cedent | t's Usual Oc | cupatio | n (Give kii | nd of wo | ork done | 16b. | Kind of Busi | ness/Inc | dustry | |
| 2 hours afte "natural", Examiner | ted | Elementary/Secondary (0-12) | | e (1-4 or 5+) | dui | ring mo | ost of working | g life. [| O NOT u | se retire | ed) | | | | | |
| 036 thin 72 hours aftene. ne. r than "natural", ledical Examiner | Completed | 10 | | , | F | Iome | emaker | • | | | | 0 | wn Hor | ne | | |
| 5-00. led with Hygiene other t | m o | 17. Father's Name (First, Middle | Last) | | | | | 18 | . Mother's | Name (| First, Middle | . Maiden | Surname) | | | |
| filed Hyging of oth | C | Elmer Welling | | 14.0 | | | , | | | , | . Knij | | , | | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | B | _ | | | 10h | Mailing | Address | | | | | | lity or Town | State : | Zin Code) | |
| D 2 shoul nd N is m | ² | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 4109 53rd Place, Bladensburg, MD 20710 | | | | | | | | | | | Otato, E | 2.6 0000) | | |
| e, MD 21215-0036 I and 2 should be filted within 72 hours after death with the Maryland Haland Hygiene Fiten 27 is marked other than "natural", or items 23a or 28a-f sher traumatic event, the Medical Examiner must be notified at once | | Gaylon A. Kni | pe / Mot | | 0b. Place of I | | | | | auen | Date . | | Location - 0 | City or T | own State | |
| Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 Injury or other traum | | 20a. Method of Disposition 1 X Burial 2 Cremation | n 3 Remov | | | | ner place) | UI CEIII | stery, | | Date | 1200. | Eddallon C |) (i) (i) | om, otato | |
| Pages ent o | | 4 Donation 5 Other S | | | Mount 0 | live | et Ceme | etery | , | 3/: | 10/200 | 9 Wa | shing | ton, | , DC | |
| nit. J | | 21 nature of Funeral Service | Licensee | | | 22. N | lame and A | dress | f Facility | | | 4730 | 0 Rolt- | imore | e Avenue | |
| Berr Dep | 1 8 | Thunker Pan | Rosas | | | Gas | sch's | Fun | era1 | Ноп | e. PA. | Hyat | tsville | , M | D 20781 | |
| Physician | _ | 23a. Part I. Erfter the disease, or | r complications th | at caused the d | eath. Do not e | enter th | ne mode of | dying, s | uch as ca | rdiac or | respiratory a | rrest, sh | ock, or hear | t | Approximate Interval | |
| Medical | 9 | failure. List only one cause | N Aud Himlo | Divint and C | horn Foro | ر ناما م | rioc | | | | | | | | Between Onset and Death | |
| aminer | | Immediate Cause (Final disease or condition resulting in death) | | Blunt and S | | e iriju | 11162 | _ | _ | _ | | | | _ | | |
| | | , | bue to (or | as a conseque | .00 01). | | | | | | | | | | | |
| | <u>-</u> | Sequentially list conditions, if any, leading to immediate | Due to (or | as a consequer | ice of): | | | | | | | | | \neg | | |
| | miner | cause. Enter Underlying Cause | | | | | | | | | | | | | | |
| + | Exan | (Disease or injury that initiated events resulting in death) Last | Due to (or | as a consequer | ice of): | | | | | | | | | | | |
| cecuted 1 and - transit | | | d | | | | | | | _ | | | | \longrightarrow | | |
| e exerian a | ≅ | UNPENDED | AMEND | ED | | | | | | | | | | | | |
| 8760, ifficate be ex ng physician as the burial | n/Medical | IF FEMALE: | 23c. lf) | es, outcome of | pregnancy | | | | | | | 23 | 3d. Date of c | lelivery | | |
| 876 tificate ing phy as the | Ē | 23b. Was decedent pregnant in t past 12 months? | the 1 L | ive birth | 2 | Fe | tal death | 3 | Ectopic | pregnar | псу | | Month | Da | ay Year | |
| Sox 687 death certific e attending p for use as th | siciar | | | regnant at time | of death 5 | Ot | her (Specif | y) | | | | - 7 | | | | |
| Box 68 e death certi the attendin | Phys | 1 Yes 2 No 9 🗸 Ur | 9 0 | nknown | | | | | | 355 | | | | | | |
| P.O. B ss that the d gned by the e detached | | Part II. Other significant condi | itions contributi | ng to death but | not resulting i | in the u | underlying o | ause gi | ven in Par | t I. | | _ | | - | he cause of death? | |
| F, P.C ires that signed | d by | | | | | | | | | | 1` | es 2 | √ No 3 | Proba | ably 4 Unknown | |
| ords, w requir | Completed | | | | | | | | | | 24a. Wa | as an topsy | | | opsy findings available ompletion of cause of | |
| SOF law r has b | [출 | | | | | _ | | | | | pe | rformed? |) de | eath? | | |
| Vital Reco ysician: The law his certificate has director, page 2 s | <u>`</u> 5 | | | | | | | _ | | | 1 ✔ Ye | s 2 | No 1 | ✓ Yes | s 2 No | |
| ian: certif | Be (| 25. Was case referred to medic examiner? | | | | | | - 1 | of Death (| | | | - | | | |
| Vit tysic I dire | , E | 1 ✓ Yes 2 No | Hospital: 1 | Inpatient | 2 ER/Out | patient | | | Other 4 | | g Home 5 | | dence 6 🗸 | _ | Scene | |
| Division of Vital Records, tal or Attending Physician: The law require as alter clean. In Director: After this certificate has been sited in by the funeral director, page 2 should be | ٦ | 27. Manner of Death | 28a. l | Date of Injury Yonth, Day Year) JND: | 28b. Ti | | Injury 28 | | at Work? | i: | 28d. Describ | | | | | |
| ion tendij eath. for: / | 흝 | | iuiiig F_L | JND: 28, 2009 | 0100 | | | 1Y | es 2 🗸 | No | oubjoor b | | | | | |
| risi r Att er de irect | <u>:</u> | 2 Accident Investigation Peb 20, 2009 10 100 fills 28f. Location (Street and Number or or Town, State) | | | | | | | | | | | | | | |
| Div tal or rs aft | ertification: | or Town, State) or Town, State) or Town, State) or Town, State) 4109 53rd Place, Bladensburg, MD | | | | | | | | | | | | | | |
| lospi 4 hou uner | ၂ ပ | 29a. Certifier 1 Certifying | Physician: To the | e best of my kno | wledge, deat | h occu | rred at the t | ime, da | te and pla | ce, and | due to the c | ause(s) a | and manner | as state | ed. | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical | (Check only one) 2 Medical Ex | aminer: On the b | asis of examina | tion and/or in | vestiga | ition, in my | opinion, | death occ | curred a | t the time, da | ite and p | lace, and du | ue to the | e cause(s) | |
| To 1 With To 0 | led | 29b. Signature and title of certif | and man | ner stated. | | | | | number | | | | | | nth, Day, Year) | |
| | 2 | Zab. Signature and the or certif | 1 | / / | D | | | O.C.1 | | | | | bruary 28 | | • | |
| 2 | | NU1 11 | | | 7 | | | U.U.I | /I. L. | | | | ordary 20 | , <u>-</u> 00 | | |
| -71 | | 30. Name and address of person | | | | | | | | | | | | | | |
| ZX | | Russell Alexander M | D. Assista | nt Medical E | xaminer | 111 | 1 Penn S | treet, | Baltimo | re, M | 21201 ט | | | | | |
| S | tate | 31. Date filed (Month, Day, Year |) / 3 | 2. Registrar's S | ignature | 1 | | | | | | | | | | |
| Regis | strai | MAR 0 9 200 | 3 Party | N B. | gav | _ | | | | | | CME | | | | |
| | | 1011 | | | . | | | | | | U | A 44 540 | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician Evelyn Jeanette Hanson 430 M Marc 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Rehabilitation + Wising Ctr lis bury ar If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 219-16-5943 84 Director Maryland 03/10/1924 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Medical Expanirer must be notified at any Injury or other traumatic event, it e Medical Expanirer must be notified at ONDE. 1 ☐ Yes 2X No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 4709 Airport Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎛 No Specify. white 2 Specify 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laundromat owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph P.Welsh Mildred Walsmey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Ann Reese/daughter 4709 Airport Rd., Salisbury, MD 21804 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 2) Signature of Funeral Service Licensee Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompos 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year-/Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonsequence of Hospital or Attending PhysIclan: The law requires that the death certificate be execute burial-tran Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2 ☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 2 410 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar MAR 0 6

31. Date filed (Month,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 28,2009 **Physician** 2:00 AM February Hartlove Linda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Stevensville 603 Zaidee Lane Oueen Anne 3irthplac Country) VA f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Funeral Hours Min Days 1 □ M 2 🛣 F 2/18/1950 West 59 219-54-4389 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examinal funt to inclined at 1 ☐ Yes 2 XNo MD Stevensville Director Queen Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21666 USA 603 Zaidee Lane Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married Baltimore, Maryland 21215-0036 White 1 □Yes 2X No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk Annapolis City Elementary/Secondary (0-12) College (1-4or 5+) 01 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any injury or other traumatic ev L. Nea1 Shirley Lawrence Richard ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 603 Zaidee Lane Stevensville, MD 21666 David G. Hartlove III Spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 3/5/2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to for as a consequence of Examiner the burial-trans and Due to (or as a consequence of) attending physician for use as the burial certificate be Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 □ Yes 2 ₩ 0 4 ☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 sl performe 1 □Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner⁴ Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 □Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital

within 24 hours a To the I State Registrar

29b. Signature and title of certifier 30. Name and address of p

4 Homicide

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) MAR 05 2009

son who completed cause of death (Item 23a) (Type Print) 13. Panb

and manner stated.

32. Registrar's Signature

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

B32030

29d. Date signed (Month, Day, Year)

Drue Cle, Le, MD 2/6/9

| | | 1 | State of Maryland / D State of Maryland / D Registrar | epartment of F Certificate of | | lental Hygi Re | ene 2009 | 09056 | | | | |
|----------------------------|---|-------------------|---|---|---|--|---|---|--|--|--|--|
| | Physicia | n | 1. Decedent's Name (First, Middle, Last) Elenie Lucille Hylton | | | 2. Date of Death Month March | 02 2009 | 3. Time of Death 6:45 AM | | | | |
| | /Medic Examin | al - | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, o | or Location of Death | riai Cii | 4c. County of Deatl | | | | | |
| | Lxamiii | | 2574 Riva Road, Unit 13A | Annapo | | | Anne Aru | | | | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birth | hday) If Under 1 Year Months Days | | 8. Date of Birth (Month, Day, 03/13/19 | Year) 9. Birth 252 Mary | nplace (State or Foreign Intry) Land | | | | |
| | 0 | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | or Location | | | | 10d. Inside City Limits | | | | |
| | Maryla f shov ied at | to | Maryland Anne Arundel Annapo | | | | - 4 | 1 ☐ Yes 2 ☐ No | | | | |
| | or 28a | Director | 10e. Street and Number | 10f. Zip Code | | 10 | g. Citizen of What Co | • | | | | |
| | sth wi | eral [| 2574 Riva Road, Unit 13A | 21401 | Hispanic Origin? (Sp | ecify Yes or No- | United Sta | | | | | |
| 36 | within 72 hours after death with the Maryland glene. Than "natural", or items 23a or 28a-f show than "natural" or items 24 be notified at the Medical Evaminer must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: | 13. Was Decedent of If Yes, specify Cub 1 □ Yes 2 ☑ No | | Rican, etc.) | No- 14. Race - American Indian, Black, White, etc. Specify: White | | | | | |
| | 72 hou natura ilical E | | 15 Decement's Education 16a. | Decedent's Usual Occu (Give kind of work done life. DO NOT use retire | pation during most of work | ing 1 | 6b. Kind of Business/ | ndustry | | | | |
| 121 | within 72 iene. than "na ne Medic | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | Manager | ed) | 1 | Food Servi | ce | | | | |
| nd z | be filed tral Hy dothe | Be | 17. Father's Name (First, Middle, Last) George N. Bounelis | | 18. Mother's Nam Lucille | e (First, Middle, M M. Doughe | aiden Surname) erty | | | | | |
| ary | shou and N s mar | ြ | | Mailing Address (Stree | | | | | | | | |
| | ss 1 and 2 of Health item 27 i r other tra | | 001111 21 3 1111, 2 1 1 | 6 Yorktown | | | Oc. Location - City or | | | | | |
| ם ב | Pages nent of I | l g | 11 Burial 2 #4 Cremation 3 L. Hemoval from State | Disposition (Name of y, crematory or other pla Crematory | | 3/2009 E | dgewater, | Maryland | | | | |
| Baltimore, | permit. Pages Department of Important; If it any Injury or o once. | | 21. Signature of uneral Service Licensee | 22. Name and Addr | ess of Facility Ge | orge P. | Kalas Fune | ral Nome | | | | |
| n | 80 E 29 | | on First State Washington and Amplications the Course of the death Do. | | | | Edgewater, | | | | | |
| - | Physician | e y | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. LUNG CANCER resulting in death) | | mig, odon do odrado | or respiratory arro | | Approximate Interval Between Onset and Death Onths Months | | | | |
| | /Medical Examiner | | Due to (or as a consequence of | of): | | | | | | | | |
| | p # | ner | Sequentially list conditions, if any, leading to immediate dauds. Entire Uniderlying Cause (Disease or injury that initiated events | of): | | | | | | | | |
| o, | cate be executed physician and the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of | of): | | | | | | | | |
| 8760, | cate be physici the bu | dical | d | | | | | | | | | |
| D. Box 6 | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours a ler dea.h. To the Funeral Director Atter this certificate has been signed by the attending prompletely filled by the funeral director, page 2 should be detached for use as | sician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnan 5 ☐ Other (specify) | ncy | | 23d. Date of de Month | ivery Day Year | | | | |
| ds, P.O | w requires that the de been signed by the should be detached | by Phy | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause g | iven in Part I. | | acco use contribute to | the cause of death? | | | | |
| ecor | e law requ has been je 2 should | Completed | | | | 24a. Was ar autops perform | y prior to | atopsy findings available completion of cause of | | | | |
| a | sician: The certificate rector, page | | 25. Was case referred to medical | | 26 Place of Dea | | No 1 □Yes | 2 🗆 No | | | | |
| ₹ | Physicia this cert af directo | o Be | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou | utpatient 3 □ DOA O | thar | 11 | nce 6 ☐ Other (Spe | cify) | | | | |
| 0 0 | ling Ph | [:uo | 1 Matural 5 □ Pending (Month, Day, Year) | Time of 28c. Injury Wo | uryat ork? ⊒Yes 2 ⊒No | 28d. Describe ho | w injury occurred | | | | | |
| Division of Vital Records, | To the Hospital or Attending Physician: The within 24 hours at et death. To the Funeral Director Atter this certificate he completely filled by the funeral director, page | Certification: To | 2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rura City or Town, State) | | | | | | | | | |
| _ | To the Hospital within 24 hours a To the Funeral Completely filled | Medical Ce | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination are and manner stated. | e, death occurred at the nd/or investigation, in my | time, date and place opinion, death occu | e, and due to the corred at the time, do | ause(s) and manner a ate and place, and du | s stated. e to the cause(s) | | | | |
| | To the within To the comple | Me | 29b. Signature and title of certifier | 29c. Licer | nse number | 20 29 | 9d. Date signed (Mon | h, Day, Year) | | | | |
| | - EO! |) | CM -MD | 110 | 106/1/ | 7 - | 1-1-70 | 9 | | | | |
| | S. Consultation | | 30. Name and address of person who completed cause of death (Item 23a) Jay Rhee, 900 Bestgate Road, Suite | (Type, Print) 300, Annap | olis, Mary | land 2140 | 1 | | | | | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) MAR 0.5 2009 32. Registrar's Signature | | | | | | | | | |

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| | | 1 | State Registrar | | | | Cer | tificat | e of L | Death | F | Reg. No. 2009 090 | | | | |
|--------------------------------|---|---|---|-------------------------|-------------------------|-------------------------|-------------------------------------|----------------------|------------------|-------------------|-------------------------|--------------------------------------|-----------------|-----------------------|----------------------------------|---------------|
| | | | 1. Decedent's Name (First, I | Aiddle, Last, |) | | | | | | 2. Date of Dea Month | Day | Year | 3. Time of | | |
| | Physicia /Medic | | Anne Brook | s Hei | 1and | | | | | | 1 | February | 28 | 2009 | 0410 | Ам |
| | Examin | | 4a. Facility Name (If not inst | tution, give | | | | | | Location | of Death | , | 4c. Coun | ty of Death | | |
| 1 | | | SAIN'T AG | INES | HOS | PITAL | - | _ | | IMOF | | | N/ | | | |
| | Funeral | | 5. Social Security Number | 6. Se | х]м 21 ⊽]F | | s. last birthday) | If Under Months | 1 Year Days | If Under Hours | Min. | Apate of Big Apate, be Mar | Year) | 9. Birthp | place (State on try) yland | or Foreign |
| | Director | | 219-40-771 | | - M - X | | 64 Yrs. | | | | | MAL. | - 134 | Plai | yrand | |
| | and w | | Usual Residence of Deceder 10a. State 10b. Co | | | 10c. C | City, Town or Lo | cation | | | | | | 1 | 0d. Inside Ci | ty Limits |
| | f sho | ō | Maryland An | ne Ar | rundel | Τ, | inthic | num | | | | | | | 1 ☐ Yes | 2 X No |
| | the N | Director | 10e. Street and Number | | | | | 10f. Zip | Code | | | | I 0g. Citizen o | f What Cour | ntry? | |
| | with 3a or | | 302 Regenc | v Cir | rcle | | | 2 | 2109 | 0 | | บร | SA | | | |
| | ns 2; | 11 Marital Status 12. Was Decedent Ever in U.S. | | | | | | | dent of H | ispanic Or | igin? (Spec | cify Yes or No- | | ace - Americ | | |
| (0 | fler of riter | | 1 ☐ Never Married 2 反 | Married | Armed Fo | 2 N O | | i Yes, spei I∐Yes | - | Specify. | n, Puerto F | nican, etc.) | | ack, White, | | |
| 03 | urs a | by | 3 ☐ Widowed 4 ☐ Dive | | If Yes, G Year or D | ates: | | I 🗆 res | ZA NO | эреспу. | | | Spec | B1 | ack | |
| 2-0 | be filed within 72 hours after death with the Maryland rtal Hygiene. And Hygiene. Ad other than "natural", or items 23a or 28a-f show event, it a feed for a feed of the than the feed of | Completed | 15. Dec (Specify only I | edent's Edu | cation le completed) | | 16a. Dece | kind of wo | rk done o | during mos | st of workin | ng i | 16b. Kind of | Business/In- | dustry | |
| 21 | ithin ithin in ithin | n ple | Elementary/Secondary (0- | | College (| | | DO NOT u | | | | | _ | | | |
| 2 | ed wi | | 12th | | 0 | | <u> Nur</u> | sinc | 1 As | | | (First, Middle, | Crowns | | e Hos | pital |
| pu | be fill Ital H id oth | Be | 17. Father's Name (First, Mi | | | ٦ | | | | | | th Fe | | | | |
| <u>6</u> | ould Mer Marke narke | ၉ | Paul Raymo | | | | 40h Maillin | | (Ctroot | | | I Route Numbe | | | Code) | |
| <u>e</u> | 12 sh hand 7 is n raun | | 19a. Informant's Name/Rela | | | - N | | _ | | | | | | | | |
| ď | Healt | 1 | Gary Heila 20a. Method of Disposition | na (Hi | ıspano | | | | | | | Linth: | 20c. Location | | | |
| وَّ | iges if it | | 1 XBurial 2 ☐ Crema | | | State | .(Place of Displo cemetery, crer | | | | 3-6- | 00 | Glen | Durn | io M | a |
| Baltimore. Marvland 21215-0036 | it. Pa rtmei rtant njury | 1 | 4 ☐ Donation 5 ☐ Oth | | | 141 | lemoria | | | | - | Morti | | | ie, m | .u. |
| B | permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, II. II. Once. | | 21. Signature of Furieral Se | NICE LICENS | | - 1 | | | | | | apolis | | | Ω1 | 0 |
| | | | 23a. Part 1. Enter the disea | se. or comp | | caused the de | | | | | | | | 211 | Approximat | e |
| | | 8 0 | shock, or heart failure Immediate Cause (Final | . List only o | ne cause on | each line. | | | | | | | | | Interval Bet Onset and | Death |
| | Physician /Medical | | disease or condition resulting in death) Ta. Pnum n ia T-10 dcu Due to (or as a consequence of): | | | | | | | | | | | | | acrys |
| | Examiner | | Noutmpenia. >5 yrs | | | | | | | | | | | | | irs |
| | | ē | Sequentially list conditions, if any, leading to immediate | • | Due to | (or as a conse | equence of): | | | | | | | | | |
| | cuted id ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Chronic Myelogenous Leukemia 11978 Due to (or as a consequence of): | | | | | | | | | | | | <i>b</i> | |
| _ | an ar rial-tr | | resulting in death) Last | | Due to | (or as a conse | equence of): | J | | | | | | | | |
| 68760 | Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Medical | | | d | | | | | | | | | | | |
| č | ng ph as ti | Med | IE EEMALE: | | | | | | | | | | 1 | - | | |
| S S | eath certific attending p for use as t | | | | | | | | | | | Date of deliv Month | - | Year | | |
| 9 | e des the at | Physician/ | 1 □Yes 2 No 9 □ Unknown | | 4 □ Pre 9 □ Unk | gnant at time o nown | of death 5 L | Other (s | pecify) _ | | | | | | | |
| A a | d by | P _y | Part II. Other significant co | anditions of | antributing to | death but not r | esulting in the u | nderlyina | cause div | en in Part | l. | 23e. Did to | obacco use co | ontribute to t | he cause of | death? |
| 7 | res the signer liber d | \$ | Diab | | Mell | | | | 3 | | | 1 1 1 | ′es 2∐No | 3□ Pro | bably 4 🗖 | Unknown |
| w g | w requires that the debe should be detached | eted | | | | mia | | | | | | 24a. Was | | | opsy findings | |
| HEL | e law has t | Completed | Chro | nic_ | Ane | mia | | | | | | l autor | ISV | prior to co death? | impletion of o | cause of |
| | sician: The la certificate ha lirector, page 2 | | | | | | | | | | | | rmed? 2 X No | 1 ☐ Yes | 2 □No | |
| in \$ | certil recto | Be | 25. Was case referred to mexaminer? | - | Hospital: | 6 | T 50/0 4:-4/- | | Oth | | | <i>(Check only o</i> me 5 ☐ Resid | | Dah a | :4.1 | |
| ANNE ANNE | or Attending Physafter death. Director: After this lin by the funeral director | l E | 1 ☐ Yes 2 No 27. Manner of Death | | 28a. Dat | e of Injury | ER/Outpatie | | 28c. Inju Wor | | | 28d. Describe I | | | 119) | |
| ₹ 5 | Afte fune | ţi | 1 X Natural 5 ☐ F | Pending nvestigation | (Mo | nth, Day, Year, |) Injury | м | Wor 1 □ | kî?]Yes 2.[| □No | | | | | |
| | or Attend after death Director: | fica | 3 ☐ Suicide 6 ☐ 9 | Could not be determined | 28e. Plac | e of Injury - At | t home, farm, st ecify) | reet, factor | y, office | | 2 | 28f. Location (S | Street and Nu | mber or Rur | al Route Nur | nber, |
| <u>َ</u> | - 5£±c | Certification: To | 4 ☐ Homicide | 201011111101 | buil | aing, etc. (Spe | еспу) | | | | | City or Tov | vii, State) | | | |
| | To the Hospital of within 24 hours at To the Funeral D completely filled i | | 29a. Certifier 1 Ce | ertifying Ph | ysician: To the | ne best of my l | knowledge, dea ination and/or i | th occurre | d at the t | ime, date a | and place, | and due to the | cause(s) and | manner as | stated. to the cause/ | s) |
| | he Ho in 24 he Fu pletel | Medical | one) | | and ma | nner stated. | | | | | | | | | | |
| | To t To tl | Z | 29b. Signature and title of o | certifier | , × | 10 | | 29 | | se number | | | 29d. Date sig | | | 200 |
| | | - | 1000 | | | | | | F2: | 2002 | | | Februo | ry, | 28, 20 | 707 |
| | Van. | JU) | 30. Name and address of p | | completed ca | use of death (I | tem 23a) (Type, | Print) | Ω | NITI | nno = | MI | 2.12 | 29 | | |
| | War. | | RADHIKA KA | | 32 | Bodistrar's Sig | nature | | | HUIII | ,,,,,, | , , , , , | | | | |
| | Sta Regist | ate rar | MAR | 06 20 | 09 | Luca . | B. 4 | all | | | | | | | | |
| | | | 111111 | | 14 | | 1 7 | 1.04 | | | | | | | | |

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| lth d | Jе | pc 3/12/09 d | se Type or | Print in of Maryla | | | | | | | | | le. | | |
|--------------------|-------------------|--|--|-------------------------------------|-------------------------------|------------------------------|--------------------------------|-----------------|----------------------|------------------------------------|-----------------------|-----------------------------|-------------------|------------------------------------|-----------|
| | | For State Registrar | Oldio c | n maryia | | ertificat | | | | iontai 11 | Reg. N | | 9 | 090 | 158 |
| 0.0 | - | 1. Decedent's Name (First, Midd | le, Last) | | | | | | | 2. Date of E | Death | | | 3. Time of | Death |
| /sicia: /ledica | | Margaret Har | ris | | | | | | | FEBA. | UAR | 14 26 | lear | 4:5 | AM |
| ine | 4 4 | 4a. Facility Name (If not institution | | | | | Town, o | r Location | n of Death | | | 4c. County of | | | |
| - 4 | | Future Care | | | | | | nolo | | | | | | unde1 | |
| | | 5. Social Security Number 214-20-7716 | 6. Sex 1 □ M 2 X □ F | 7. Age (In yrs | 99 Yrs | Months | | Hours | er 24 Hrs. Min. | 8. Date of B (Month, E Nov 2 | ay, Yez 28 1 | 1909 S | Cour | olace (State on ontry) Carol | |
| | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | City, Town or | Location | | | | <u> </u> | | | 1. | Od. Inside Ci | tu Limite |
| | jo | | timore | | | imore | : | | | | | | | 1 TYes | - |
| 1 | Sire. | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. (| Citizen of Wh | at Cour | ntry? | |
| 100 | <u>a</u> | 7051 Greenba | | 212 | | | | | USA | | | | | | |
| | Funeral Directo | 11. Marital Status | Was Dece If Yes, spe | dent of H | lispanic C an, Mexic | Origin? (Spe can, Puerto | ecify Yes or N Rican, etc.) | lo- | 14. Race - Black, | Americ White, | | | | | |
| 1 | by | 1 ☐ Never Married 2 ☐ Mar 3 ☐ XWidowed 4 ☐ Divorced | 2 X No ive oates: | | 1 🗆 Yes | ¾ ☐ No | Specif | fy: | | | Specify: | B1: | ack | | |
| Post | ted | 15. Deceder | it's Education | | 16a. De | cedent's Usu | al Occup | ation | | | 16b. | Kind of Busi | | | |
| 1 1 1 | Completed by | Elementary/Secondary (0-12) | st grade completed) College (| 1-4or 5+) | life | ve kind of wo e. DO NOT u | irk done se retire | during mo d) | ost of work | ing | | | | | |
| 8 | 5 | 8th | 0 | | As | semb1 | уL | | | | | | | tons : | Inc. |
| 6 | e R | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surn | | | | | | | | | · · · · · · · · · | | | | |
| F | 0 | Alfred Meachem Annie Froneberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, | | | | | | | | | | | | | |
| | | Delores Oden | | | | B & | | | | | | | | | |
| | ŀ | 20a. Method of Disposition | | 20b. | | | | | | erna Date | т — | Location - Ci | _ | | |
| | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Rest Cemetery 3-3-09 Hanov | | | | | | | | | nover | - 1 | 5N | | |
| | ŀ | 21. Signature of Funeral Service Licensee Warmame Rockes of SeciliSons Mortuary, P.A. | | | | | | | | | | | | | |
| | | 23a. Part1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | | | | |
| | edical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | REPRO (or as a conse | equence of): | NIAR | | ISEA |)SE | | | | | Onset and D | |
| Maciologian | Pnysician/medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | | | | | | | | | | * | 'ear | | |
| | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F | | | | | | | | | | ne cause of de ably 4 □U | | | |
| oto | erec | P. M. C. S. M. | 14110 | | | | | | | | | <u> </u> | | | |
| uma | Completed by | CONGESTIVE | | - | LURI | | | | | per | opsy formed? | prid dea | or to cor ath? | psy findings a npletion of ca | use of |
| _ | | chronic rena 25. Was case referred to medica | | re . | | | | ac Plac | so of Dooth | 1 ☐ Yes Check only | 21/2 | No 1 [|]Yes | 2□No | |
| B C | 0 | examiner? 1 Yes 2 No | Hospital: | Inpatient 2 | ∃ER/Outpat | ient 3 DC | Oth | | | me 5□Res | | 6 □Other | (Snecifi | d) | |
| T .uc | | 27. Manner of Death Natural 5 ☐ Pendir | 28a. Date (Mon | of Injury oth, Day Year) | 28b. Time | of 2 | 8c. Injur Worl | | | 28d. Describe | | | | ·/ | |
| ratio | gati | 2 Accident investi | gation | | | M | 10 | Yes 2 | □No | | | | | | |
| Cartification. | | 4 Homicide determ | ined 28e. Place | of injury - At I ing, etc. (Spec | home, farm, : sify) | street, factory | , office | | 2 | 28f. Location City or To | (Street a own, Sta | and Number ite) | or Rura | l Route Numb | er, |
| | | (Check only 2 Medical | ng Physician: To the Examiner : On the b | asis of examin | nowledge, de nation and/or | ath occurred investigation | at the tir | me, date a | and place, a | and due to the | e cause | (s) and mann | er as st | ated. | |
| Modical | Med | one) 29b. Signature and title of certifie | and man | ner stated. | _ | | | e number | | | | | | | |
|) | - |) nane | n'm | 1) | | 1230 | | | 531 | | _ | ate signed (i | | 26, Za | |
| | | 30. Name and address of person | who completed caus | se of death /Ite | m 23a) (Tun | e. Print) | | | | | | | | - | |
| | | Mohit No | 26 | se of death (Ite | Te va. | MI. | 4 | 6 | r 20 | 4 | h.1 | 10.1.1 | 11 | 000 | 97.11 |
| tate | 9 | 31. Date filed (Month, Day, Year) | 2000 32/ | Registrar's Sign | nature | , , , , | 71 | au_ | de of | , | | 1 CY JUL | ue | 1119 | 4/1 |
| trai | r | שטאאש | ZUUS CEN | me, | 3. A | arked | | | | | | | | | |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 8:00 A Dona1d Ingram March 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Brighten Gardens Asst. Living Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1∏M 2□ F Days Jan 5, 82 Virginia 578 34 7774 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 □ Yes 2√CNo Howard Columbia Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7110 Minstrel Way 21045 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Tables 2 No WWII
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 录 No Specify. Specify: White 3XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Univ of Maryland Technical Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eleanor MacCormick Howard Ingram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13777 Brighton Dam Road, Clarksville, MD21029 Heather Sanial (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Congressional Cemetery 3/7/2009 | Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 m00257 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimeris Disease disease or condition resulting in death) 4 vears Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D56531

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

March 4, 2009

Examiner and Box 68760, The law requires that the death certificate be Physician:

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

၉

Examine

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

Funeral

Director

Item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Modical Examinar must he notified at

al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental H. Important: If Item 27 is marked oth any injury or other traumatic event

Physician

/Medical

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar physician the burial attending properties for use as as Ö the detached signed by t ٥. Division of Vital Records, peen page 2 s has certificate After this funeral (Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Registrar

31. Date filed (Month, Day, Year) State MAR 0 9 2009

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, 8600 Snowden River Pkwy #301, Columbia, MD 21045

32. Registrar's Signature mena

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D

| | | | _ FOI | epartment of Health and M Certificate of Death | , , | ene .No.2000 00060 | | | | | | | |
|--------------------------------|--|---------------------------|--|--|--|--|--|--|--|--|--|--|--|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Year 3. Time of Death | | | | | | | |
| | /Medic | al | Edna May Jones 4a. Facility Name (If not institution, give street and number) | 4h City Tayun and acadian of Dooth | March 4 | • 2009 1030 AM | | | | | | | |
| | Examin | er | Calvert County Nursing Center | 4b. City, Town, or Location of Death Prince Frede | rick | Calvert | | | | | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho | (ay) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y | th 9. Birthplace (State or Foreign Country) | | | | | | | |
| | Director | | Usual Residence of Decedent | | Feb 8, 1 | 916 Washington DC | | | | | | | |
| | arylan show | ō | 10a. State 10b. County 10c. City, Town of MD Prince George's Fore. | r Location stville | | 10d. Inside City Limits 1 ☐ Yes 2 【 No | | | | | | | |
| | the M | rect | 10e. Street and Number | 10f. Zip Code | 10g | J. Citizen of What Country? | | | | | | | |
| | tth with 23a or ust be | ralD | 2507 Roslyn Ave | 20747 | U | nited States | | | | | | | |
| 980 | be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White | | | | | | | |
| 2-0 | 72 hou | Completed | 15. Decedent's Education 16a. De (Specify only highest grade completed) (6 | ecedent's Usual Occupation tive kind of work done during most of worki te. DO NOT use retired) | ng 16 | b. Kind of Business/Industry | | | | | | | |
| 121 | within liene. • than ' | ompl | Elementary/Secondary (0-12) College (1-4or 5+) | nemaker | | OwnHome | | | | | | | |
| pu | oe filed tal Hygi d other event, t | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | | · · | | | | | | | |
| ryla | should be fand Mental s marked o | ၉ | Charles Vernon Mackintosh 19a. Informant's Name/Relationship (Type. Print) 19b. N | lailing Address (Street and Number or Rura | May War | | | | | | | | |
| Ma | d = 17 | | | O Richfield Road, Hu | | | | | | | | | |
| Baltimore, Maryland 21215-0036 | Pages nent of ant: If it | | | sposition (<i>Name of</i> crematory or other place) March 1 ection Cemetery | 70,2009 C | c. Location - City or Town, State | | | | | | | |
| Balt | permit. Departr Importa any inju | | 21. Signature of Funeral Service Licensee mo/5-33 | Home,Inc 6633 01d ton, MD 20735 | | | | | | | | | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause queach line. | | | | | | | | | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Atherosci | ascular | difease | | | | | | | | |
| | Examiner | | Due to (or as a consequence of): | | | | | | | | | | |
| | ted sit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Decree of Light) that initiated events conditions to the condition of | | | | | | | | | | |
| o, | tificate be executed g physician and as the burial-transit | ш | that initiated events c | | | | | | | | | | |
| 68760, | cate be physicia the bu | edical | d | | | | | | | | | | |
| O. Box | ath cer attendin for use | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of delivery Month Day Year | | | | | | | |
| rds, P. | w requires that the de been signed by the should be detached | d by Pr | Part II. Other significant conditions contributing to death but not resulting in the | acco use contribute to the cause of death? | | | | | | | | | |
| Division of Vital Records, | The law rec ate has bee page 2 shou | omplete | TIYPENTENSI'VE HEART D'LOCK 24a. Was an autopsy find to complet death? 24b. Were autopsy find to complet death? | | | | | | | | | | |
| /ital | Physician: The la this certificate ha ral director, page 2 | BeC | 25. Was case referred to medical examiner? | 26. Place of Death | 1 Yes 2 (Check only one) | ₫No 1 □ Yes 2 □ No | | | | | | | |
| of/ | Physician: r this certificaral director, | | 1 | | me 5 Residence | ce 6 Other (Specify) | | | | | | | |
| ion | ath. r: Afte | atior | 1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) Inju 2 ☐ Accident investigation | le of 28c. Injury at york? M 1 □ Yes 2 □ No | | ,, | | | | | | | |
| Divis | tal or Atte | Certification: To | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify) | street, factory, office | 28f. Location (Stree City or Town, S | 8f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| | To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | Medical (| 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, c 2 Medical Examiner: On the basis of examination and/c and manner stated. | eath occurred at the time, date and place, or investigation, in my opinion, death occurr | and due to the cau ed at the time, date | se(s) and manner as stated. e and place, and due to the cause(s) | | | | | | | |
| | Vith To th | Σ | 29b. Signature and title of certifier Your . C . Luron | 29c. License number | 1 | Date signed (Month, Day, Year) | | | | | | | |
| Ď | | ŀ | 30. Name and address of person who completed cause of death (Item 23a) (Ty | | Curr | 3-5-2009 | | | | | | | |
| 5 | \$5 | | 5851. Deale Churchte | 9/1/10 | reale | mp. 20751 | | | | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NAR 0 9 2009 32. Registrar's Signature | backer | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State of Maryland / Department of Health and Mental Hygiene 2 State Amend Items 25,26,29a per dr. 9889,03/26/09dhb Registrar AMEND#7,8perFH3/6/09,BW,Moco Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 08:06 Johnson Feb 2009 Bessie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges

9. Birthplace (State or Foreign Country) Southern Maryland
5. Social Security Number Hospital Clinton Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country)
CCT 26, 1916
CCT 27, 1926South Carolina **Funeral** Months Days Hours Min 82 1 □ M 2 € F Director 578-38-4348 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Maxical Examinat must be notified at once. 1 Yes 2 □ No Director Suitland Prince Georges 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 20746 3710 Leeds Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖳 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Asst. US Army years Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Bufford ပ Isaac Hammond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) d 3710 Leeds Drive Suitland Md. 20746

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State <u> John A. Johnson - Husband</u> 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Washington Nat. 3-07-2009|Suitland, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3831 Georgia Ave. Latney's Funeral Home Washington, # 278 DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician disease or condition resulting in death) Medical Due to (or as a cons guence of): Examiner Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to to as requires that the death certificate be executed AMIA and that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): 68760. physician Physician/Medical use as attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Ö the detached 9 Unknown 9 Unknown py ۵. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Records, s been signe should be c Completed by 2 🚺 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie Feb. 26,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEISO Scott 7503 Surreits ROAD CLINTON, MD 20735

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

06

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28 2009 **Physician** 0345 February Herbert Johnson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day May 10 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex ^{Year)}924 **Funeral** Months 1 ₹ M 2 □ F Maryland 84 219-16-1112 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ?? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eventing must be invitfied at 1√2 Yes 2 □ No Annapolis Director Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 29 West Washington St. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√z No Specify Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Cement Finisher 0 2 should be filed with and Mental Hygier is marked other the 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Washington Sam Johnson ပ Department of Health and Important: If Item 27 is maan injury or other traumat once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Md. 21401 525 Royal St. Ebby Owens (Daughter) 20c. Location - City or Town, State 20b. Blace of Disposition (Name of Demisiety Greinburg) or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 3-6-09 Memorial Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Windame Redese of &cilisons Mortuary, P.A. m00483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA **Physician** /Medical Due to (or as a consequence of): Examiner END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy Live birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) I Yes 2 □ No ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed beta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 1 Depatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) Injury 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Medical

31. Date filed (Month, Day, Year) MAR U 6 2009

29b. Signature and title of certifier

29a. Certifier

2120 FONDE RUAD SILVER SPRIST MO MITCHELL 32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D39037

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2009

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death 1 . 2009 MARCH 11, **Physician** MARY LOUISA ESENWEIN KELLEY 09:30P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4865 EASTERN NECK ISLAND RD. KENT ROCK HALL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 10/28/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □XF 88 Director 220-16-9317 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show items 23a or 28a-f shortners in the recognition of the continued the rectified at 1 ☐ Yes 2 No Director KENT ROCK HALL MD death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 4865 EASTERN NECK ISLAND RD. 21661 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 7 is marked other than "natural", or i traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: \$ WHITE 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY FRANCES MASLIN HENRY MOHR ESENWEIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other troonce. 4863 EASTERN NECK ISLAND RD. ROCK HALL, MD 21661 KELLEY REUWER/GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/16/09 ROCK HALL, MD 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer Lon /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2 □No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: A d in by the f 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide of Funeral Dire settles of Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Millin, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Chestertown, MD 21620

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar Signature

| | | 1 | For State Registrar | | State of Ma | i yiaiiu | | tificate of L | | | Reg. No | 0000 | 09064 | | | | |
|---|---|---|--|-------------------------|--|---|------------------------------|--|---|--------------------------------|--------------------------------|--|---------------------------------|--|--|--|--|
| | Physicia | an | 1. Decedent's Name (Firs | | | 2. Date o | Da | 2009 Year | 3. Time of Death 1600 P M | | | | | | | | |
| | /Medic | al | GEORGE PAT | | | | Т | 4b. City, Town, or | Location of Deat | | H 10, | | | | | | |
| | Examin | er | | | OSPITAL CEN' | TER | | CHESTER | | | | | | | | | |
| , _ | Funeral | | 5. Social Security Number | | | | st birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date o | f Birth n, Day, Year, | 9. Birth | place (State or Foreign intry) | | | | |
| | Director | | 215 -46-914 | | Mary | yland | | | | | | | | | | | |
| | M A | | Usual Residence of Dece 10a. State 10b. | edent County | | 10c. City, | Town or Loc | cation | | | | | 10d. Inside City Limits | | | | |
| | f sho | ō | Total State | | | | | | | | | | 1 □ Yes 2 □ No | | | | |
| | . 28a- | Director | 10e. Street and Number | 1110 | | One | 350150 | 10f. Zip Code | | | 10g. C | itizen of What Cou | intry? | | | | |
| 3 | 23a ol | | 402 Morgne | c Rd | Apt 3c | | | 21620 | | | US | A | | | | | |
| | ems; | Funeral | 11. Marital Status | | 12. Was Decedent E Armed Forces? | | . 13. V | Vas Decedent of H f Yes, specify Cuba | ispanic Origin? (S ın, Mexican, Puer | Specify Yes o to Rican, etc | r No- | Race - Amer Black, White | | | | | |
| 30 | s arre | by Fu | 1 Never Married 2 | | 1 ∏Yes 2 ☑ N If Yes, Give Year or Dates: | 0 | 1 | I∐Yes 21∑ No | Specify: | | | Specify: | nito | | | | |
| Š . | 72 hours arter death with the Maryland Inatural", or items 23a or 28a-f show Linal Examiner must be notified at | | | | | | | | | | 16b. l | White 16b. Kind of Business/Industry | | | | | |
| 0 | nin 72 in "na Medic | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Syrs 15. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired) Carpenter | | | | | | | rking | | | | | | | |
| 7 | filed within Hygiene. other than " ent, the Me | E S | | | | | | | | | | | | | | | |
| B | be file tal Hy d oth event | Be | 17. Father's Name (First, | | st) | | | | 18. Mother's Na | · | | n Surname) | | | | | |
| <u> </u> | 2 should be filed w h and Mental Hygie is marked other t raumatic event, th | မ | William A. | | (Tong Drint) | | 10b Mailin | ng Address (Street | Elizabe | | | or Town State 7 | in Cade) | | | | |
| Ma | d 2 sh th and 7 is n traun | | 19a. Informant's Name/F Jennifer De | | Daughter | | | Austin (| | | | | ,,, | | | | |
| ē, | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. It of Health and Mental Hygiene. Or item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at | | 20a. Method of Disposition | | Daughter | 20b. Pla | | sition (Name of natory or other place | | Date | | ocation - City or | Town, State | | | | |
| e E | Pages ent o nt: If i | | 1 ☑xBurial 2 ☐ Cre 4 ☐ Donation 5 ☐ | | Removal from State cify) | | | | | 3/2009 | Mil: | lington, | MD | | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once. | 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 4 Donation 5 Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN | | | | | | | | | | & NEWNAM FUNERAL HOME ERTOWN, MD 21620 | | | | | |
| | | | 23au art 1. Enter the di | sease, or co | omplications that caused | the death. | | | | | | J 21620 | Approximate Interval Between | | | | |
| (5 | bucicion | F 75 | shock, or heart fail Immediate Cause (Fina | lure. List or | ily one cause on each lin | ie. | | | | | | | Onset and Death | | | | |
| Too | hysician / /Medical | | Immediate Cause (Final disease or condition resulting in death) a. PNEUMON./T Due to (or as a consequence of): | | | | | | | | | | | | | | |
| me de la | Examiner | | Comportially list condition | nno. | b. END S | 5 (or as a consequence of): 5 STAGE CHRONIC OBSTRUCTIVE REMOVARY >10) 6 (or as a consequence of): | | | | | | | | | | | |
| 30 | p t | iner | Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury) | iate g | Due to (or as | a consequ | ence of): | | | | - 60 | JETTIG | | | | | |
| | xecute and I-trans | Examiner | that initiated events resulting in death) Last | У | c Due to (or as | a consequ | ence of): | | | | | | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | al E | | | d | | | | | | | | | | | | |
| | | ledical | | | <u> </u> | | | - | | | | | | | | | |
| Вох | law requires that the death certifi as been signed by the attending . 2 should be detached for use as | Physician/M | IF FEMALE: 23b. Was decedent pred | | 23c. If yes, outcome 1 ☐ Live birth | | | ☐ Ectopic pregnand | су | | | 23d. Date of del Month | ivery Day Year | | | | |
| П | e dear the att | sicis | in the past 12 mon 1 ☐ Yes 2 ☐ No | | 4 ☐ Pregnant a 9 ☐ Unknown | t time of de | eath 5[| Other (specify) _ | | | _ | World | 24, 104 | | | | |
| P.O. | hat th od by 1 letach | Phy | 9 Unknown | nt condition | s contributing to death b | ut not resu | ulting in the u | inderlying cause giv | en in Part I. | 23e. | Did tobacco | use contribute to | the cause of death? | | | | |
| of Vital Records, | iires ti signe d be c | d by | Tarrin Garler digitimesan | | , | | Ü | | | | 1 Yes | 2 | obably 4 🗆 Unknown | | | | |
| Sor | v requ been shoul | Completed | | | | | | | | 24a. | Was an | 24b. Were au | topsy findings available | | | | |
| Re | The lay ate has page 2 | m m | | | | | | | | ` , | autopsy performed? Yes 2 | death? | completion of cause of | | | | |
| to | sician: The certificate rector, page | | 25. Was case referred t | to medical | | | | | 26. Place of De | ath (Check | | io i les | 2 🗆 110 | | | | |
| <u> </u> | Physician: r this certific ral director, p | o Be | examiner? 1 ☐ Yes 2 No | | Hospital: 1 🗖 Inpatie | ent 2 🗆 | ER/Outpatie | nt 3 □ DOA Oth | ner: 4 🗌 Nursing | Home 5 | Residence | 6 □Other (Spe | cify) | | | | |
| 0 | ng Ph fter th neral | l ii | 27. Manner of Death | Pending | 28a. Date of Inju (Month, Da | ıry ıy, Year) | 28b. Time of Injury | Wor | rk? | 28d. Des | cribe how in | ury occurred | | | | | |
| Sio | Attending r death. ector: Afte by the fune | catio | 2 Accident | investiga | at ho | | | | Yes 2 □No | 20f Loca | tion /Ctroot | and Number or B | ural Route Number, | | | | |
| = | or At after d Direct in by | Certification: To | 4 Homicide | determin | | | | reet, factory, office | | | or Town, Sta | | mai rioute rumboi, | | | | |
| _ | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | | (Check only 2 | Certifying Medical E | Physician: To the best xaminer: On the basis of | of examina | wledge, dea tion and/or i | th occurred at the t | ime, date and pla opinion, death oc | ce, and due curred at the | to the cause time, date a | (s) and manner a and place, and due | s stated. e to the cause(s) | | | | |
| | the Ithin 24 thin 24 the F | Medical | one) | | and manner st | ated. | | | se number | | | Date signed (Mont | | | | | |
| 29b. Signature, and title of certifier D004158 | | | | | | | | | 7 | | 3-12- | | | | | | |
| | 6 | | 30. Name and address | of person v | ho completed cause of c | death (Item | n 23a) (Type. | | • | • | | | | | | | |
| | 1115 | | Dr. Hele | n Nob | le, M.D. 1 | 22 Sp | reer : | Rd. Chest | ertown, | MD 2 | 1620 | | | | | | |
| | St | ate | 31. Date filed (Month, L | MAR. | 1 3 2009 A | ar's Signa | ture | bode | | | | | | | | | |
| | Regist | ror | | CITAL . | T O PANA D V X | Tarabana. | <i>a O</i> . | STATE OF THE PARTY | | | | | | | | | |

DHMH 17 Rev 1/2001

| | | | 1 - For State Registrar | State of Marylar | | artment of F | | | giene 009 | 09065 | | | |
|--|--|-------------------------------|--|--|---|---|---|---|---|---|--|--|--|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last, | Ki26 | | | | 2. Date of Dea Month | Day Year | 3. Time of Death | | | |
| | Examin | | 11-10 | Ale NURS'X | here | 5 | Lishun | | 4c. County of Dea | 4c. County of Death Wilcomico | | | |
| | Funeral Director | | 5. Social Security Number 6. Security Number 1883–18–7507 Usual Residence of Decedent | IM 2DE | last birthday) 37 Yrs. | If Under 1 Year Months Days | If Under 24 litrs. Hours Min. | 8. Date of Birth (Month, Day 10/14/1 | v, Year) Co | Year) Country) | | | |
| | a-f show | ctor | 10a. State 10b. County MD Worcester | | ty, Town or Lo | ocation oke City | | | | 10d. Inside City Limits 1X Yes 2 □ No | | | |
| | h with th | al Dire | 10e. Street and Number 1001 Market Stree | | . Citizen of What Country? USA | | | | | | | | |
| 980 | 72 hours after death with the Maryland Instural, or Itame 23e or 28s-f show Jose Exacting must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Ever in U Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: WWI] | | 21851 Was Decedent of H if Yes, specify Cubin 1 ☐ Yes 2X No | lispanic Origin? (Si an, Mexican, Puerti Specify: | pecify Yes or No- pecify Yes or No- pecify Yes or No- | 14. Race - Ame Black, Whit | | | | |
| 21215-0036 | S - 3 | Completed | 15. Decedent's Edu (Specify only highest grad | cation e completed) College (1-4or 5+) | dent's Usual Occup kind of work done DO NOT use retired | during most of wor | king | 16b. Kind of Business/Industry Manufacturing | | | | | |
| Maryland 2 | ba da ba | To Be Co | 17. Father's Name (First, Middle, Last) John Ralph King | | | | 18. Mother's Nam Ruby Var | | Maiden Surname) | | | | |
| d) | end 2 sh lealth and m 27 ia m har traum | | 19a. Informant's Name/Relationship (Ty Ralph King (son) | | 1043 | Buck Harl | oor Rd., | Pocomoke | e City, MD | 21851 | | | |
| Baltimore, | it. Page itment o rtant: If njury or | 20a. Method of Disposition 1 | | | | | | | | | | | |
| Ba | Depa Impo any to |) | 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or compl | A Dean | 10 | 3 Linden | Ave., Po | ocomoke (| City, MD 21 | tional Association ty, MD 21851 Approximate | | | |
| | be be executed by sician and be be executed by sician and be burial-transit by sician and burial by sician and burial bur | I Examiner | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | hrive | | | Interval Between Onset and Death | | | | | | |
| P.O. Box 68760, | Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | d. 3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c | Ideath 3 | Ectopic pregnancy | , | | 23d. Date of de Month | ivery Day Year | | | |
| | quires that in signed t uld be deti | ٥ | Part II. Other significant conditions con | ntributing to death but not res | sulling in the u | nderlying cause giv | en in Part I. | | bacco use conIribute to es 2 □ No 3 □ Pt | | | | |
| Il Records, | : The law requirele hes been page 2 shoul | Completed | | | | | | 24a. Was a autop perfor 1 Yes | | ulopsy findings available completion of cause of 2 No | | | |
| of Vital | ysician: Th is certificete director, pag | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | lospital: 1 ☐ InpalienI 2 ☐ | ER/Outpatien | nt 3□ DOA Oth | | th <i>(Check only or</i> ome 5□ Resid | ne) lence 6 □Other (Spe | cifv) | | | |
| Division of | ding After | Certification: 7 | 27. Manner of Death 1 Natural 5 Pending investigation | 28a. Dale of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injur Wor | | | ow infury occurred | | | | |
| Divi | 9 # 12 E | | 3 Suicide 6 Could not be determined | Street and Number or Ri n, State) | | | | | | | | | |
| 29a. Certifier Continue Cont | | | | | | | | cause(s) and manner as date and place, and due | s stated. to the cause(s) | | | | |
| 29b. Signalure and title of certifier 29c. License number 29d. Date signalure and title of certifier 25c. License number 27c. License number | | | | | | | 29d. Date signed (Mont | | | | | | |
| | | | 30. Name and address of person who co | empleted cause of death (Iter | п 23а) (Туре, | | | | 03/02/ | 2002 | | | |
| B | A3+1 | | 30. Name and address of person who come bulation is a second of the seco | # 106 Million | d ST | # 504 | B, Sall | SBAYY, | 177218 | 501 | | | |
| 8 | Sta Registr | | NAR 0 5 200 | | D. 400 | uke | | | | | | | |

| | | | For | State of Maryl | | | | Mental Hy | giene 🤈 | nna | nones |
|----------------------------|--|-------------------|---|--|-----------------------------------|---|---|--|-------------------------------|-------------------------------------|--|
| | | | State Registrar | | C | ertificate of | Death | | Reg. No. | .000 | 0 9 0 0 0 |
| | Physicia | | 1. Decedent's Name (First, Middle, Lasi | KOWAL | YSH' | YNI JA | LV | 2. Date of Dea Month MARCH | Day | 2009 | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, give | street and number) | 1 - 1 . | 4b. City, Town, o | or Location of Dea | | | ounty of Death | |
| | | | Howard county | General 1 | ospita | | word | | | Hour | 4 |
| E | Funeral Director | | 5. Social Security Number 6. Se 15 83–18–1394 | 7. Age (İn | yrs. last birthda 89 Yrs. | y) If Under 1 Year Months Days | If Under 24 Hrs Hours Min | | h y, Yea <i>r)</i> L919 | 9. Birthp Coun PA | place (State or Foreign ntry) |
| | and W | } | Usual Residence of Decedent 10a. State 10b. County | 10c | . City, Town or | Location | | | | 1 | 0d. Inside City Limits |
| | Maryla fed at | tor | MD Howard | C | olumbia | | | | | | 1 □Yes 2XXXIII |
| | r 28a | irec | 10e. Street and Number | | <u>JI GIROTA</u> | 10f. Zip Code | | | 10g. Citize | n of What Coun | itry? |
| | th with | Funeral Director | 6529 Carlinda Ave | | | 21046 | | | USA | | |
| | tems | nue | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | in U.S. 1 | Was Decedent of I If Yes, specify Cub | Hispanic Origin? (oan, Mexican, Pue | Specify Yes or No rto Rican, etc.) | - 14 | . Race - Americ Black, White, e | |
| 30 | be filed within 72 hours after death with the Maryland nat Hyglene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 24a or 28a-f show event, I'm Modeal Evan in a the rediffed at | by F | 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced | 1 | | 1 □ Yes 2 🔀 No | Specify: | | S | pecify: Wh: | ite |
| 5-0036 | 2 hou | | 15. Decedent's Ed | ucation | 16a. De | cedent's Usual Occu ve kind of work done | pation | nrkina | 16b, Kind | of Business/Inc | dustry |
| 7 | thin 7 ne. Ian "n | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life | e. DO NOT use retire | ea) . | Jinnig | | . =1 | |
| 121 | led w Hygier her th | Ö | 17, Father's Name (First, Middle, Last) | 4 | Elec | trical En | _ | ame (First, Middle, | | inghouse | 3 |
| and | d be fi ental I ced ol c eve | o Be | Stephen Kowalyshy | m | | | Anna Ku | | | | |
| \rightarrow | should I and Men is marke | ပ္ | 19a. Informant's Name/Relationship (7 | | | ailing Address (Stree | | | | | Code) |
| Mar | s 1 and 2 shows the substitution of the substitution in the substitution is a substitution of the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitution in the substitution is a substitution in the substitu | | Robert Kowalyshyr | | | Severn D | | | | | |
| Baltimore, | Pages 1 nent of H int; If iten iry or oth | | 20a. Method of Disposition 1 | | | sposition (Name of rematory or other pla | | Date | | ation - City or To | · |
| | | | 4 ☐ Donation 5 ☐ Other (Specify 21. Signatury of uneral Market Licen | | | awn Cemet | ery 3-1. | 1-2009 | | iottsvi e's Fam | ile, MD ily FH, İnc |
| Ra | permit. P Departm Importal any inju | | 21. Signatur of uneral to the Licen | see MOI | 411 | 4112 Old | Columbia | Pike, E | llico | tt City | , MD 21043 |
| Ė | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only | olications that caused the one cause on each line. | death. Do not | enter the mode of dy | ring, such as cardi | ac or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| 1 | Physician | 7 | Immediate Cause (Final disease or condition | a. Candi | is pul | . asson | t | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a cor | | 1-12-00 | re Oles | | | | |
| | | er | Sequentially list conditions, if any, leading to immediate | b. Sever | isequanta of): | normor | - Constant | | | | |
| | cuted id ansit | Examiner | it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | · PUD | | | | | | | |
| Ö, | icate be executed physician and the burial-transit | I Ex | resulting in death) Last | Due to (or as a cor | nsequence of): | | | | | | |
| 8760 | cate b | dical | | d | | | | | | | |
| 9 X | leath certific attending p | //Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pr | | | | | 23 | d. Date of deliv | ery |
| . Box | death e atte | icia | in the past 12 months? | 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time | | 3 ☐ Ectopic pregnar 5 ☐ Other (specify) | | | | Month | Day Year |
| о. О | at the de I by the a stached i | Physician/Me | 9 Unknown | 9 Unknown | | | in a Death | 220 Did 1 | obacco use | a contribute to t | he cause of death? |
| Š | iires that signed I d be det | by | Part II. Other significant conditions of | ontributing to death but no | t resulting in th | e underlying cause g | iven in Part I. | | Yes 2□ | | bably 4 Hhknown |
| Ö | w requir s been si shouid I | Completed | 0.0 . (1.0 | | | | | 24a. Was | an | 24b. Were auto | opsy findings available |
| æ | ; The law icate has l ; page 2 s | dmo | | | | | | - auto | psy ormed? | prior to co death? 1 □Yes | ompletion of cause of |
| ā | siclan; T certificat rector, pa | BeC | 25. Was case referred to medical | | | | 26. Place of D | 1 □ Yes eath (Check only | 2 No one) | 1 Lifes | 2 🗆 NO |
| > | Physicl this ce al direc | | examiner? 1 □ Yes 2 □ No | | | tient 3 1 DOA | | Home 5 ☐ Res | idence 6 | □Other (Speci | fy) |
| ם ס | ding Pł h. After tł funeral | :uo | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Ye | ar) 28b. Tim Inju | ry Wo | | 28d. Describe | how injury | occurred | |
| Division of Vital Records, | ttend death. | icati | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | At home, farm. | | □Yes 2□No | 28f. Location (| Street and | Number or Rur | al Route Number, |
| <u>></u> | al or Al | Certification: To | 4 Homicide determined | 28e. Place of Injury - building, etc. (S | ipecify) | | | City or To | wn, State) | | |
| | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical C | 29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar | nysician: To the best of m niner: On the basis of exa and manner stated. | y knowledge, o amination and/o | eath occurred at the or investigation, in my | time, date and pla y opinion, death oc | ace, and due to the ccurred at the time | cause(s) a , date and p | and manner as a place, and due t | stated. to the cause(s) |
| | To the Hos within 24 h To the Fun completely | Me | 29b. Signature and title of certifier | () | | | nse number | | | signed (Month, | Day, Year) |
| | | | Misalai | 7 | | | 4372 | | | ch (6 | 107 |
| (| (0)02 | | 30. Name and address of person who | completed cause of death | (Item 23a) (Ty 5755 | pe, Print) Ledar L | are C | olumbe | al | nn o | 21044 |

State Registrar

31. Date filed (Month, Day, Year) WAR 10 2009

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 9:58 A M Cynthia Koehler **Physician** Irene 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner omico at Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number Funeral Months Days 1 □ M 2 🕱 F 56 Yrs 213-60-9658 12/10/1953 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State if them cars manked other than "natural", or items 23a or 28a-f show or other traumatic event, I've Medical Exprimentiate by modified at 1 ☐ Yes 2X No Director Maryland Wicomico Delmar 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event 21875 USA 28853 Adkins Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 □Yes 2 X No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Bounds Marion Austin ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6500 Hagueman Dr., Richmond, VA 23225 Kimberly Tindall/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/09 Glen Burnie, MD Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. END STAGE CHROMIC OBSTRUCTIVE PULMONARY DRSEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed and that initiated events use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached for 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, been signe should be d Completed by 1 ☐ Yes 2 ☐ No 39 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1□Yes 2戸No 1 Yes this certificate To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Gother (Specify) HOSPICIZ 1 Yes 2/ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Division 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the of certifier

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State Registrar

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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BOX 173? SAUSBUY UP 21802

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ursula Carlotta Kendall $3:35 a^{M}$ 2009 March 5, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Silver Spring Renaissance Gardens at Riderwood Village If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 84 217-44-8806 June 21, 1924 PA Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD Silver Spring 1 Yes 2XXNo Director Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or i ury or other traumatic event, the Medical Evantines must be a 20904 USA 3160 Gracefield Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ★No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2XXXNo Specify ģ 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Catholic Church 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Giovanna Morelli Carlo Caligure ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Hemsley Drive, Queenstown, MD 21658 Charles H. Kendall / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XX remation permit. Page Department or Important: If any injury or once. 3 ☐ Removal from State March 5, 2009 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Sign sure of Funeral 500 University Blvd. West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissaco of niju) that initiated events resulting in death) Last Due to (or as a consequence of). Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🔀 No P.O. cate has been signed by the page 2 should be detached 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2**XX**No 1 ☐Yes 2 🔀 No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4XXNursing Home 5 - Residence 6 - Other (Specify) 1∐ Yes 2🛛 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 ☐ Accident 5 Pending investigation iours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the Hosp within 24 ho To the Fune completely f and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D36716 March 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew George Kundrat 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 06 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Eleanor Karakashian A M 6:35 March 5. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gaithersburg Montgomery Wilson Health Care Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Year) 1 ☐ M 21 F Aug. 10, 1937 Washington, DC 578-54-2116 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 X Yes 2 □ No Maryland | Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 403 Russell Avenue #612 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ∐Yes 21K No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music/Education Piano Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Lydia Nazarian <u>Jacob Kasab</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 403 Russell Avenue #612, Gaithersburg, MD 20877 Nishan Karakashian (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 3/9/09 Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Funeral Service ofer Approximate Interval Between Onset and Death 23a. Pat 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Liver Cirrhosis Years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 X No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 🗌 Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 □Yes 2 □No 2 Accident

Box 68760 P.0. Division of Vital Records,

certificate be executed and burial-trar attending physician the nse fo the detached has To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral After 1

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

1 and 2 Health a

permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State Registrar

Medical

29b. Signature and title of certifier

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

19294

🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

March 5, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven Dolinsky, M.D., 911 Russell Avenue, Gaithersburg, MD 20877

31. Date filed (Month, Day, Year) MAR 06

6 ☐ Could not be

3 Suicide

29a. Certifier

4 Homicide

(Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2009 Year Month Day March 2, PAUSE STEPHEN 11:55 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood 8. Date of Birth (Month, Day, Yea 9/20/1926 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 € M 2 □ F Months Days Hours Min 385-20-1180 82 Wisconsin Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 953 Heather Way 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1949–68 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 24 No Specify Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Minski Stephen Felix Krause 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eleanor F. Krause/ Daughter 829 Fort Hunt Rd., Alexandria, VA 22308 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 📈 Cremation 3 ☐ Removal from State 3/4/09 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home M 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEtastali 7 4RS resulting in death) Due to (or as a consequence of). Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) HOSPICE Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred CHESA PEAKE 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Records, P.O. Box 68760, Division of Vital

Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran sate has been signed by page 2 should be detacl certificate After this n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examination to profile of the profil

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

2

Completed

Be

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Physician/Medical Examiner

2

Completed

Be

Medical Certification: To within 2 State Registrar

30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) Arif Hussain, M.D.

31. Date filed (Month, Day, Year) MAR U5 2009

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6 □ Could not be

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and manner stated.

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) March 3: 2009

State of Maryland / Department of Health and Mental Hygiene U Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 2009 11:21 AM Joan Kriss /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Ye Ian. 26, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year Hours 1 □ M 2√√ F 1929 126-22-7969 80 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Exambles found by notified at 1 ☐ Yes 🎗 😾 No Director Maryland Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 United States 930 Bay Forest Court Apt 306 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ∏Yes 2 XXV If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21√21No ģ Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Juvenile Parole Officer State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Sauve Felix Kriss ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellen F. Culler / Daughter 107 River Point Court Simpsonville, SC 29681 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 3/5/2009 Baltimore, Maryland 21. Signature of Funeral Service Liq 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Much 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischamic 1mm disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 59 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed muneur burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the 1 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 ☐ Unknown 1 🗆 Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perforn certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Mann of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADEEB 2001 Madical

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR U 6 2009

32. Registrar's Signature

MNUDOLIT

| 9-02072 lichael Kinney | | | | | Departme | nt of | f Health | and | | | | gible. | 200 | 9 0907 | |
|--|----------------|--|----------------------|--|--------------------------|----------------|---|----------------|--------------------|------------------------------|--------------------------|-------------|---------------------------------------|--|--|
| | F | - For State Registrar | | | Certifica | te of | Death | | | 1. | | eg. No. | 200 | , ,,,,, | |
| Physicia: ledical Examin | er | Decedent's Name (First, Midd Michael Paul K | | | | | Month Day Year March 13, 2009 | | | 3. Time of Death 1510 hrs | | | | | |
| | П | 4a. Facility Name (if not institution Northwest Hospital | n, give street a | and number) | | | 4b. City, To Randal | | | f Death , | | | ounty of Deat timore Co | | |
| Funeral | | Social Security Number | 6. Sex | 7. Age (| In yrs. last birth | day) | If Under | | If Under | 24Hrs. | 8. Date of Bi | | /YYYY) 9, Bi | thplace (State or | |
| Director | | 232-21-3609 | 1 X M 2 | | 29 | Yrs | Months | Days | Hours | Min. | 6/24/ | 1979 | Forei | gn puntry) WV | |
| and a supplier of the growing and | | Usual Residence of Decedent | | | | | | | | <u> </u> | | | | | |
| d wany | | 10a. State 10b. County 10c. City, Town or Location MD Baltimore Reistertown | | | | | | | | | | | 10d. Inside City Limits 1 Yes 2 X No | | |
| - I sho | ٥ | 10e. Street and Number | | | | | | `odo | | | 1. | 10a Citizor | 0g. Citizen of What Country? | | |
| th the Maryland 23a or 28a-f show any notified at once, | Dir. | 207 Log House | Way | | | | 10f. Zip C | 211 | 36 | | | USA | | | |
| er death wi | Fune | 11. Marital Status 1 X Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married 2 Never Married Never Mar | es, specify | Decedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. White, etc. Specify: White | | | | | | ican Indian, Black, hite | | | | | |
| ours:af | 황 | 15. Decedent's Education (Spe | or Dates | š: | | | nt's Usual O | | | | | 16b. Kind | d of Business | /Industry | |
| imore, MD 21215-0036 Pages I and 2 shouldbe filed within 72 hoursafter then of Health and Mental Hygiene. Inten 27 is marked other than "natural" or other traumatic event, the Medical Examing. | Completed | Elementary/Secondary (0-12) | Col | lege (1-4 or 5+ |) | | nost of working life. DO NOT use retire iler | | | | ed) | Au | Auto Care | | |
| 21215-0036 Mortal Hygiene. marked other than cevent, the Medica | | 17. Father's Name (First, Middle | , | | | | | 1 | 8.Mother's | | First, Middle, | | | | |
| 121 the fi ental l nrked vent, | 8 | Donald Paul K | | | | | | | | | Chery1 | | | | |
| re, MD 212 I and 2 should be Heath and Menta fitem 27 is marke | _ | 19a. Informant's Name/Relation: Donald Paul Ki | | Father | | | - | | | | nie, M | | or Town, Stat | e, Zip Code) | |
| Baltimore, permit, Pages I and Department of Head Important: If item injury or other tra | | 20a. Method of Disposition 1 X Burial 2 Crematio | n 3 Rem | ioval from State | 20b. Place of cremato | | sition (Name ther place) | of cem | etery, | | Date | 20c. Loc | cation - City o | r Town, State | |
| Pages | | 4 Donation 5 Other S | | oval nom state | Victor | y_Ce | emeter | су | | 3/1 | 8/2009 | A1m | a,West | VA | |
| Balt permit Depart Import | | 21. Signature of Funeral Service | | | | | | | | | | | 1 Home | , P.A. | |
| | -1 | 23a. Part I. Enter the disease, o | complications | that caused th | ne death. Do not | 112 enter t | Ridge | ely dving s | Ave. | An: | napoli respiratory ar | s, MD | 21401 | Approximate Interval | |
| Physician /Medical xaminer | | failure. List only one cause Immediate Cause (Final disease or condition resulting in death) | on each line. | othermi | ia compluence of): Ca | lica | ating | alc | | | | | | Between Onset and Death | |
| | | Sequentially list conditions, | b. | or as a conseq | uses on of): | _ | | _ | | | | | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | | or as a conseq | derice or). | | | | , | | | | Profession of | | |
| sit sd | Xar | events resulting in death) Last | Due to (| or as a conseq | uence of): | | | | | | | | | | |
| and | ig l | XUNPENDED | d | IDED 23a. | ,27,28a | -f.r | erME. | 98 | 89 3, | /26/0 | 09 TT | | | | |
| frate be exe g physician at the burial - | ē | IF FEMALE: | | If yes, outcome | | -) [| | 80 | 0, 0, | | | 1004 1 | Date of delive | | |
| Box 68760 : death certificate b the attending physical cd for use as the bu | ₩ | 23b. Was decedent pregnant in a past 12 months? | | Live birth | or pregnancy 2 | Fe | etal death | 3 | Ectopic | pregnar | псу | | onth | Day Year | |
| lox 687 eath certific | Sicia | past 12 months? 4 Pregnant at time of death 5 Other (Specify) | | | | | | | | | | | | | |
| b. B. the de ched f | Physicia | Part II. Other significant cond | 9 | Unknown uting to death t | but not resulting | in the | underlying o | ause di | ven in Pa | rt I. | 23e. Did | tobacco us | e contribute te | the cause of death? | |
| s, P.O. Boires that the de signed by the | <u>۾</u> | | | J | | | , , | Ü | | | 1Y | es 2 1 | No 3 Pro | bbably 4 🗸 Unknown | |
| cords law requestable has been 2 should | Completed | | | | | _ | | | | | | | | utopsy findings available completion of cause of | |
| Vital Rec ysician: The his certificate director, page | Be C | 25. Was case referred to medic | | | | | _26 | | of Death (| (Check o | niy one) | | | | |
| Vit | ೭ | examiner? 1 ✓ Yes 2 No | Hospital: | inpatient | t 2 🗸 ER/Ou | | | <i>"</i> | Other ₄ | | Home 5 | Residenc | | er: | |
| n of ding Phr. | | 27. Manner of Death 1 Natural 5 Death | dina | a. Date of Injury (Month, Day,Yea | ar) | ime of | · · · | | y at Work | . 10 | 28d. Describe exposu | re to | LOW | | |
| Division ratendin or Attendin rs after death. | cati | Natural 5 Pending Investigation 2 X Accident 8 Pace of Injury At home, farm, street, factory, office building, etc. 1 28e. Place of Injury At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura) Route Num or Town, State) 20 Log House | | | | | | | | | | | | | |
| Divis pital or At ours after d neral Direct filled in by | Certification: | | Id not be crmined (S | four | nd on di sidence | rive | eway o | f | andrig, or | | or Town, | | | tural Route Number, City House Way | |
| Fun Fun tely | | 29a. Certifier 1 Certifying F | | the best of my | knowledge, dea | | | | | | due to the cau | use(s) and | manner as sta | | |
| To the Hos within 24 h To the Fun completely | Medical | 2 🖳 | and ma | basis of exami anner stated. | ination and/or in | vestiga ——— | | | | curred at | trie time, date | | | | |
| | 2 | 29b. Signature and title of certif | H | 200 | an | | 1 | O.C.N | number M.E. | | | | nte signed <i>(M</i> h 14, 2009 | onth, Day, Year) | |
| | | 30. Name and address of perso | | | | Donn | Street, B | altima | oro MAD | 21204 | - | • | - | *** | |
| | - 1 | Carol Allan, MD As | oloralit ivi6 | dical Exam | mici IIII | CIIII | Oucet, D | anunit | , e, IVIU | Z 1201 | • | | | | |

State 31. Date filed (Month, Day, Year) Registrar MAR 18 2009

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 11:54pm Jesus Herminio Lezcano 2009 March 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 29 216-64-7170 Cuba **Director** January 24, 1920 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Montgomery Derwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20855 USA 16121 Crabbs Branch Way items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 6 1 X Yes 2 No Specify: Cuban Baltimore, Maryland 21215-0036 Specify: White 2 3 X Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) At torney **Government** 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even once. Be Jorge Lezcano Ana Rosa Pastor ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabel Maria Betancourt / Daughter 18909 Abbotsford Circle, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ②XCremation 3 ☐ Removal from State Metropolitan Crematory March 8, 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blwd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Acute Respiratory Failure /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I I Inknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 □Yes 2XXNo director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1**∏**{Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only To the within 2. and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hubby MD Manan D62562 March 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhavi Hubbly 9901 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 09 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 7:20 AM LEEWOOTEN MARY 07 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BERLIN WORCESTER MD ATLANTIC HOSFITAL GENERAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 12/16/1914 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 💢 F MD 94 218-30-2238 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 1 ☐ Yes 2 X No Berlin Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 10218 Old Ocean City Rd. Apt.801 21811 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? nmed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 ∐XNo Specify: Specify: white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mid Wife Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Turner Lee Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12234 Greenridge Lane, Ocean City, MD 21842 Sharon Mitchell Parsons 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2009 Berlin, MD 21811 Evergreen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Fulleral Service Licensee The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Ent. The dise 1. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one couse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, the ball of the late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse mence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner physician and s the burial-trans ed by the attending I Records, Division of Vital

Physician/Medical Examiner

Completed

Certification: To

Medical

State

Registrar

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "notical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event tong."

Physician

116!

0

8

Funeral Director

Completed by

Be

MD

/Medical

certificate | To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

Natural 2 Accident 3 Suicide

4 Homicide 29a. Certifier

6 Could not be determined

21811

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated 29b. Signature and title of certifier munder

29c. License number 00062130

MO

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Healthway James Ancia 9733

31. Date filed (Month, Day, Year)

10

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 MARCH Betty Ann Lowe 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HICOM 100 3A41364R4 Come REGIONAL TENINSULA f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2 🙀 F 6/4/1928 218-24-2597 80 MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No Whaleyville MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21872 USA 7937 Circle Rd. 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 **X** No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify. White 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beatrice Sirman Preston West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dana West / nephew 7937 Circle Rd., Whaleyville, MD 21872 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/2009 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. Frankford, DE 21. Signature of Fune al Service Lioensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Turbol 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intraci Idays disease or condition resulting in death) Due to (or as a consequence of): Directo (or as a fronse guence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

/Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours a To the Funeral L Hospital

burial-tran and attending physician for use as the burial Physician/Medical s been signed by the should be detached þ Be Completed certificate has b funeral director, Certification: To After this s after death.

I Director: Af in by the fur filled in by Medical

Physician

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it will find Examinat must be notified at

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Department of Health ar Important: If item 27 is any injury or other trau

Physician

Pages 1

72 hours after death with

3altimore, Maryland 21215-0036

/Medical

Director

Funeral

à

Completed

| 25. | Was case | | to medica |
|-----|----------|------|-----------|
| | 1 ☐ Yes | 2 No | |

6 Could not be determined 3 Suicide

4 Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

100 E. CARROLL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

| (Check on one) | y 2 Medical I |
|-------------------|------------------------|
| 9h Signature | and title of certifier |

30. Name and address

and manner stated.

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

RA 6

State Registrar

completely

Year) 31. Date filed (Month Oav. MAR U 5 2009

EllEDA

ZIEMER, P.O. 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Day **Physician** 12:10 A M Adeline Clara Lumpp 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7/23/1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 91 351-01-3561 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show yinjury or other traumatic event, the Medical Evaluation and the notified at once. Director 1 ☐Yes 2 X No MD Wicomico Pittsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 35181 Betty Court 21850 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married /outsess at oc Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: \$ white 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Douglas Thome Lillian Theresa Davis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35181 Betty Court, Pittsville, MD 21850 Arlene Shills / daughter DOD 03/Baltimore, N 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/3/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 ☐ Other (specify) P.O. neral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached it 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? - ot - 356 i ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ı ∐Yes 2 No 1 Yes 2 **X**10 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier .০০প D006 4120

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State Registrar 31. Date filed (Month, Day, Year)
MAR 0 5 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

3 Health way Drive Berlin M'D 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:05 A M 2009 March Speros James Leanos 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Edenwald Retirement Community Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 214-05-1611 Oct.28, 1916 New York Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2/17 No Maryland Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 United States 800 Southerly Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No 1943— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 **∑**Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🏋 🕅 No Specify: White Widowed 4 Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Wholesale Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Spirits Sales Rep. Wine & Spirits 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Speros Leanos Anna Katsereles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James S. Leanos / Son 1401 Walnut St. Apt 605 Philadelphia, PA 19102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greek Orthodox Cemetery 3/7/2009 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death mmediate Cause (Final Due to (or as a conseque Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show int or other traumatic event, the Marical Examinar must be notified at

Department of Health Important: If item 27 any injury or other troone.

Baltimore, Maryland 21215-0036

Physician disease or condition resulting in death) /Medical **Examiner** Seque tially list coolings if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician for use as the buria Physician/Medical 23b. Was decedent pregnant in the past 12 months? been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed certificate has birector, page 2 s after death.

Director: After this certific 25. Was case referred to medical examiner? Be 1 ☐ Yes Certification: To 27. Manual of Death X Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o and manner stated. 29d. Date signed (Monfh, Day, Year) 29c. License number

who completed cause of dea (Item 🌬) (Type, Print)

State Registrar 30. Name and addre

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31. Date filed (Month, Day, MAR 06 2009

s of person

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 MARCH 4, 11:40 A M HARRY SIDNEY MCGINNES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death KENT CHESTER RIVER MANOR CHESTERTOWN If Under I Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye 8/5/1918 Social Security Number 7. Age (In vrs. last birthday, Year) Days 1 □XM 2 □ F 90 220-26-3106 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No CRUMPTON MDKENT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21628 USA 112 BROAD ST Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1X Yes 2 □ No 1 Never Married 2 Married WHITE If Yes, Give Year or Dates: WWII 1 ☐ Yes 2X No Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) POST OFFICE POSTAL CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BERTHA WALLEN HARRY FRANKLIN MCGINNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 248 CRUMPTON, MD 21628 WILLIAM MCGINNES/SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/09 CHESTER CEMETERY CHESTERTOWN, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service Licensee SPEER RD. CHESTERTOWN, MD 21620 130 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 3 years Due to (or as a consequence of): elve if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🔼 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a fivedical Experience must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any lijury or other traumatic event, If a Magnetic pages.

Pages 1 and 2 should be filed within 72 hours after death with

altimore, Maryland 21215-0036

burial-transit and attending physician for use as the buria been signed by the should be detached has page 2 director, this

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ģ Completed Be Certification: To

27. Manner of Death

Medical

1 Natural

2 Accident

3 Suicide

29a Certifier

4 Homicide

29b. Signature and title of certifier

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> 0 State

> > Registrar

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 ☐ Could not be

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

In D

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 35

hestatown Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Month **Physician** March 2, 1024 A M Lucinda Viola Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown Kent Chester River Hospital Center Date of Birth (Month, Day, Year) 2/1/1943 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. 1 □ M 2 □ XF Months Days Hours MD 66 Director 213-42-2450 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Marylan 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MILLINGTON KENT MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21651 Funeral 314 MIDDLE ST. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after ant of Health and Mental Hygiene. ant It Item 27 is marked other than "natural", or ite any or other traumalte event, Ite Medical Exprinisary or other traumalte event, Ite Medical Exprinisary 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **BLACK** Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FOOD Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION LINE WORKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN KENNEDY JOHN WESLEY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 314 MIDDLE ST. MILLINGTON, MD 21651 MAURICE HENRY/PARTNER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of I Important: If Ite any Injury or o once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GRAVES CHAPEL 3/7/09 MILLINGTON, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760. Physician/Medical attending private IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes after death.

Director: After this certific

In by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) Hospital: 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and 29d. Date signed (Month, Day, Year) ت HOU67888

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State Registrar D.O. 119c North M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gasparovich

Micha

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 1600PM 03/08/09 JOHN HENRY MARSHALL 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WORCESTER HARTLEY HALL NURSING POCOMOKE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 10/28/36 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In vrs. last birthday) Days Hours Min. VIRGINIA 72 228-44-8799 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1X Yes 2 □ No WORCESTER POCOMOKE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21851 1006 MARKET ST USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: BLACK 3 Widowed 4 ☐ Divorced

should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Everniner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

11 Marital Status

Director

Funeral

Funeral

Director

Physician /Medical Examiner

> Be Completed by Physician/Medical Examiner Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours. Ifter death.

To the Funeral Thrector After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| þ | 3 Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 ∐Yes | 2 A No | Specify: | | Specify: B | BLACK | | |
|--|---|---|--------------|--------------------------|-----------------|---------------------------|--------------------------|--------------------|--|--|--|
| ted | 15. Decedent's Ed (Specify only highest gra | ducation | 16a. | Decedent's Us | ual Occup | oation | 16b. | Kind of Business | s/Industry | | |
| Be Completed by | Elementary/Secondary (0-12) | College (1-4or 5+) | | | | during most of work d) | | TDE | | | |
| ٦ ا | 6 | | | LABORE | K | | | IRE | | | |
| Be | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JANIE JOHNSON | | | | | | | | | | |
| ဥ | GEORGE MARSHALL | | | | | | | | | | |
| | 19a. Informant's Name/Relationship | | 1 | Ü | , | | ral Route Number, Cit | 00101 | Zip Code) | | |
| | BETTY PETTIT - | | | 354 HO Disposition (N | | N RD., PA | | Location - City or | r Town State | | |
| | 20a. Method of Disposition 1 □ABurial 2 □ Cremation 3 □ | Removal from State | emetery | , crematory or | other pla | ce) ¦ | | | | | |
| 100 | 4 □ Donation 5 □ Other (Special | | . S. | INAI | 1 A alaba | | .4/09 WA | ARDTOWN, | MD | | |
| 21. Signature of Funeral Service Licensee 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., ACCOMAC | | | | | | | | | | | |
| 1 10 | 23a, Part 1. Enter the disease, or con | Cotyles | Don | | | | | , ACCOM | Approximate | | |
| | shock, or heart failure. List only | one cause on each line. | | | _ | | or respiratory arrest, | | Interval Between Onset and Death | | |
| l ii | Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA OF LUNG | | | | | | | | | | |
| | | Due to (or as a consequ | ience o | f): | | | | | | | |
| ē | Sequentially list conditions, if any leading to immediate | b. Due to for as a conse | ence o | fie | | | | | | | |
| min | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | |
| Exal | that initiated events resulting in death) Last | C Due to (or as a consequ | ience o | f): | | | | | | | |
| call | | ⊾ d | | | | | | | | | |
| edi | | | | - 2707 | | | | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal | | 3 ☐ Ectopic | nregnan | 21/ | | 23d. Date of de | - | | |
| sicia | in the past 12 months? 1 □Yes 2 □No | 4 ☐ Pregnant at time of d | | 5 Other (| | | | Month | Day Year | | |
| hys | 9 Unknown | | | | | | | | | | |
| by I | Part II. Other significant conditions | contributing to death but not resu | ilting in | the underlying | cause gr | en in Part I. | | | to the cause of death? Probably 4 Unknown | | |
| ted | | | | | | | 1 Tes | 2 NO 3 F | Probably 4 Unknown | | |
| ple | | | | | | | 24a. Was an autopsy | 24b. Were a | autopsy findings available ocompletion of cause of | | |
| Son | | | | | | | performed 1 ☐ Yes 2 🗷 | | | | |
| Be (| 25. Was case referred to medical examiner? | | | | 200 | | th (Check only one) | | | | |
| ၉ | 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ | | | DOA Ott | Nursing H | ome 5 Residence | 6 ☐ Other (Sp | ecify) | | |
| ino. | 27. Manner of Death 1 → Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Year) | 28b. T In | jury | 28c. Inju Wo | | 28d. Describe how in | ijury occurred | | | |
| cat | 2 Accident investigatio | 20 | fau | M | |]Yes 2□No | 28f. Location (Street | and Numberor F | Rural Pauta Numbar | | |
| Medical Certification: To Be | 4 ☐ Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | y) | m, street, facto | ory, office | | City or Town, St | ate) | nurai noute ivumbei, | | |
| alc | | hysician: To the best of my kno miner: On the basis of examina | | | | | | | | | |
| edic | one) | and manner stated. | | | | <u> </u> | | | | | |
| Σ | 29b. Signature and title of certifier | / nn N | | 2 | | se number | | Date signed (Mor | | | |
| | - Our free | / M.D | | | DO | 062172 | | 3/10/201 | 04 | | |
| | 30. Name and address of person who | completed cause of death (Item | 1 23a) (| Type, Print) | (1/- | 0 0 | | T . A . A | 21001 | | |
| Ì | SHARAD R SA | TYAL, M.D. | 004 | 14(11)(| 166 | ST FOC | omoke Ci | 14 M() | 61971 | | |

State

Registrar

31. Date filed (Month, Day, Year)

MAR 10

BAI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 09081 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 4:15 A M James J. Mammarella, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Berlin Worcester Atlantic General Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/5/1941 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**∑** M 2□ F 67 197-32-4823 Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Ocean City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21842 9900 Coastal Hwy. Unit 1002 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore, Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) Printing & Packaging Corporate Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Piccoli Joseph D. Mammarella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9900 Coastal Hwy. Unit 1002 Ocean CIty, MD 21842 Eleanor E. Mammarella 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State D'Anjolell Crematory 3/9/2009 Frazer, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service License 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. Enter the lisease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the Immediate Cause (Final Chronic obstructive pulmonary disease Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): 197 - 32 - 78 - 33Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 4, 2009 van Egmund D 0056307

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Registrar

DHMH 17 Rev 1/2001

Year) 31. Date filed (Month, Day, State MAR 1 0 2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9733 Healthway Drive, Berlin, MD 21811

2 Date of Death **Physician** James Abner Matthews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Plata *Civista* La 8. Date of Birth (Month, Day, May 30, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1 □**X**M 2 □ F Months Days Hours 1927 220-16-8573 81 Director Usual Residence of Decedent 10c. City. Town or Location 10h. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If The Marylan Event must be natified at Director Charles Indian Head Maryland 10e. Street and Number 10f. Zip Code 20640 U.S.A. 208 Bertha Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Vas Decedent — ... Armed Forces? FWes 2 No 1946-1 Ves 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify. Completed by 3X Widowed 4 □ Divorced 1947 JAME. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ATTHEWS John Matthews Mary Shelton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8937 Heathermore Blvd., Upper Malboro, Md. 20772 David N. Matthews Son 20b. Place of Disposition (Name of cemetery, crematory or other place) March 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 16, 2009 Maryland Veterans Cemetery 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funer 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) addio **Physician** lyonale /Medical Due to (or as a conuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ice off: Examiner thrive law requires that the death certificate be executed y physician and is the burial-trans al Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should Completed 24a. Was an Jas certificate 1 ☐ Yes 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 XER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a, Certifier Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier D0061652 Postofiel Rd, Waldas

Registrar DHMH 17 Rev 1/2001

State

tate of Maryland / Department of Health and Mental Hygiene Reg. No. 09082

1. Decedent's Name (First, Middle, Last)

3. Time of Death

10d. Inside City Limits

1 X Yes 2 □ No

4c. County of Death

Charles

9. Birthplace (State or Foreign Maryland

14. Race - American Indian.

10g. Citizen of What Country?

Specify: Black

16b. Kind of Business/Industry

Glass Company

20c. Location - City or Town, State

Cheltenham, Maryland

Please Type of Grint in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Approximate Interval Between Onset and Death

23d. Date of delivery Month

Year

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

> 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ATUL KAT TOLL CULC 101, 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 115abeth MARSHALL MARCE 4a. Facility Name (If not institution, give street and number) Vantage House Columbia If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□M 2√F 224-06-5008 86 1-28-1923 Austria Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√2 No Columbia (MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5400 Vantage Pt. Rd. Apt. E501 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Unknown College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HCR 72 Box 135, Rebera, NM 87560 Walton Marshall/ Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ other (Specify) Ardent Cremation 3-9-2009 Hanover, MD 21. Signature of Faneral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part I. Eurer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EUMONIA Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregrant 3 ☐ Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hiknown

Physician /Medical Examiner

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certificate has

funeral

After or Attending

To the Nespital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

physician

certificate be executed

Box 68760,

P.O. P

Division or Vital Records,

Physician:

Physician

/Medical

Examiner

Funeral

Director

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Certification:

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item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

72 hours after

es 1 and 2 should be filed w of Health and Mental Hygie f item 27 is marked other t

Department of Hee Important: if item any injury or othe

Iltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe

25. Was case referred to medical examiner? 1 Yes 2 10

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

26. Place of Death (Check only one) Cartaine Other: 4 Nursing Home 5 Residence 28d. Describe how injury occurred 28c. Injury at Work?

1□ Yes

2 No

5 Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

27. Manne of Death

1 Natural

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KENNEM GEH, MD BALTIMORE ND 21201.

10)00 Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary Ann Mills Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace 5. Social Security Number 1 □ M 2 T F Months Days Hours Min) (Month, Day, Year) 06/14/1930 Maryland 78 218-24-4961 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b County Delmar 1 X Yes 2 □ No Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21875 USA 916 E. State St., #21A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🏋 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify. white 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) seamstress shirt factory 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Minnie Marian (unknown) Leonard Thomas Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1017 Fair Winds Ct., Salisbury, MD 21801 Terri L. Griffin/daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Wicomico Memorial 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/6/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park THOTIOWAY TUNETAL Home Professionla Association 501 Snow Hill Rd., Salisbury, MD 21804 ture of Funeral Service Licensee 24 Jarrio Locaroson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final and10 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

and burial-trar attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached 24 hours a er dea h. e Funeral Director A filled in by the completely within 2 the

Physician

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Director

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Physician/Medical Examiner

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Completed

Certification: To

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be neithed at once.

Physician

Examiner

/Medical

altimore, Maryland 21215-0036

State Registrar

and manner stated. 29b. Signature and title of certifie

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause

Generall

31. Date filed (Month, Day, Year)

6 ☐ Could not be

MAROR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 Dag Jerrold Andrew Miller 151 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NICOMICO SALISALLA TENINSUM EGIONAL 10/04 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/24/1956 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours Min. 1 **X** M 2 □ F 52 Maryland 214-66-8833 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Salisbury Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 303 Brookview Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction contractor 18. Mother's Name (First, Middle, Maiden Surname) Margaret Kordish 17. Father's Name (First, Middle, Last) Robert Burl Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 303 Brookview Dr., Salisbury, MD 21804 Mary D. Miller/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/5/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signal re of Funeral Service Licensee 2 Holloway Funeral Home Professional Association Lavid 9/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): our failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traumonce.

Physician /Medical

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72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital or Attending Physician:

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Examiner attending physician and for use as the burial-tran the been signed by should be detact certificate has be rector, page 2 sl

Physician/Medical 2 funeral director, Be After this Certification: To after death. the filled in by

Completed

within 24 hours a

To the Funeral I

completely filled Medical State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

(Check only

24a. Was an autopsy performe 1 ∐ Yes 2 📈 No

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □Yes

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗵 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (rem 23a) (Type, Print) EAST

and manner stated.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 8, ^{Day} 2009 LESTER BURNETT MOSE 5:45 РМ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON HAGERSTOWN WASHINGTON COUNTY HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 8/7/1915 6. Sex 1XXM 2□ F 7. Age (In yrs. last birthday) 93 Yrs. 9. Birthplace (State or Foreign 5. Social Security Number Months Days Hours WEST 232-01-8904 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location MARTINSBURG Yes 2 No WV BERKELEY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 25404 USA 1002 N. QUEEN STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XXI 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐Yes 2 No If Yes, Give Year or Dates Specify: 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry FAIRCHILD 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (AIRPLANE MANUFACTURER) SEALER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARGARETTE ELIZABETH MULLER GEORGE WASHINGTON WHITTINGTON MOSE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13547 DONYBROOK DRIVE, HAGERSTOWN, MD 21742 BONNIE TURNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition MARCH 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE CEMETERY MARTINSBURG, WV 14, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME. 21. Signature of Funeral Service Licenses 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

traumatic event, the Medical

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Its Ma once.

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-trar Physician/Medical signed by t be detach \$ director, page 2 should Completed Be Certification: To After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu filled in by

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| 1 ∐ Yes 2 ☑ 9 ☐ Unknown | Mo | 9 Unknown | | | | |
|---|---------------------------|--|--------------------------------|---|---|---|
| Part II. Other signific | cant conditions o | ontributing to death but not res | sulting in the underlying | g cause given in Part I. | 23e. Did tobace | co use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☑ Unknown |
| | | | | | 24a. Was en autopsy performed | |
| 25. Was case referre | ed to medical | | | 26. Place of D | eath (Check only one) | |
| examiner? 1 ☐ Yes 2 ☑ N | No | Hospital: 1 patient 2 |] ER/Outpatient 3 □ | DOA Other: 4 Nursing | Home 5 ☐ Residence | e 6 ☐ Other (Specify) |
| 27. Manne of Death 1 Natural 2 Accident | | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how i | njury occurred |
| 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | nome, farm, street, factorify) | ory, office | 28f. Location (Stree City or Town, S | t and Number or Rural Route Number, tate) |
| 29a. Certifier (Check only one) | | ysician: To the best of my kn niner: On the basis of examin and manner stated. | | | | se(s) and manner as stated. and place, and due to the cause(s) |
| 29b. Signature and | itle of certifier | | 2 | 29c. License number | 29d. | Date signed (Month, Day, Year) |

State Registrar 29b. Signature and title of cer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D50362 march 9, 2009

MAR 2 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1. perMDG890, 4/6/09TT
State of Maryland / Department of Health and Mental Hygiene 2000 For State AMEND#29coenMD3-11-09, BMI, Moco Registra AMEND#1penMD3/11/09, BWI, Moco Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Billie Jo Moss 2. Date of Death 3. Time of Death Month **Physician** Day Year 5:53 PM 3 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Hours Min. May 25, 1938 Unde 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) North **Funeral** 1 M 2 X Months Days 241-56-3293 70 Director Carolina Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "social Examinat must by notified at Baltimore Director Maryland 1XXes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21201 U.S.A. 631 South Charles Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify. Specify: Black ð 3 ☐ Widowed ★ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Foreign Student College (1-4or 5+) Elementary/Secondary (0-12) Affairs(Howard Univ) Executive Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosella Simmons John Lloyd Mills ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Trudah A. Harding(Sister) 619 Allison Street, N.W. Washington, D.C. 20011 permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cem. March 5,2009 Brentwood, Md. 4☐Donation 5 ☐Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 9th Street, N.W. Washington, D.C.20011 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis nterococcal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 🗷 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s 24a. Was an autopsy performed 1 ☐Yes 2 😾 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending after death.

Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DEA P18988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boltimole, MD 21201 Green! 31. Date filed (Month, Day, Year, 2. Registrar's Signature State MAR 06 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death

Physician /Medical **Examiner**

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, the Medical Event in a remark is notified at once. d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n

Maryland 21215-0036 Completed Baltimore, Physician /Medical Examiner executed and burial-trai attending physician for use as the burial Box 68760 law requires that the death certificate be Physician/Medical P.0. à Records, page 2 should Completed certificate **Division of Vital** Physician: Be Certification: To After this funeral To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After the filled in by Medical

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month William Vance Moyer, II 9:38 P M 2009 March 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 202 Claude Street Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days XXM 2□ F 52 171-46-0961 1956 Pennsylvania May 28, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Annapolis Maryland Anne Arundel 1XXes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 U.S.A. 202 Claude Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status MXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ∐Yes **XX**No Specify: þ 3 Widowed 4 Divorced 1974-79 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Vice President Energy Finance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Paul Harold Lucas Moyer, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 202 Claude Street Annapolis, Maryland 21401 Lisl Moyer/wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 3/16/2009 Baltimore, Maryland Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate
Interval Between
Onset and Death

Lynnah, Immediate Cause (Final Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day 5 Other (specify)

in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed2 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

and manger stated.

1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Barfast, 225. Lranest, Bulbrow, My

29b. Signature and

5 ☐ Pending investigation

6 ☐ Could not be

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 05 2009

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | tate of Maryland | | rtment o | | and Mer | | ene 2 () (_I . No. | 9 | 09090 |
|------------|--|-------------------|--|---|-----------------------|--|---|--------------------------------|--|---|--|--|
| ı | Physicia | | 1. Decedent's Name (First, Middle, Last) Elizabeth Green Mas | sicot | | | | | Date of Death Month Brch | 2°, 20 | 009 | 3. Time of Death 6:46 p M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give street Tate Hospice House | et and number) | | | n, or Location of athicum | f Death | | 4c. County of Ann | | rundel |
| | Funeral Director | | 200 20 1333 | -4393 1□ M 2XI F 81 Yrs. Months Days Hours Min. | | | | | | ear) | Coun | lace (State or Foreign try) sylvania |
| | Maryland a-f show | ctor | Usual Residence of Decedent 10a. State MD Anne Arur | adel 10c. City, T | | ation a Park | | | | | 10 | 0d. Inside City Limits 1 ☐ Yes 2 🏖 No |
| | h with the 23a or 28 | Funeral Director | 10e. Street and Number 110 Lockleven Drive | | | 10f. Zip Coo | ! !1146 | | 100 | . Citizen of Wh | at Coun | iry? |
| 036 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Marical Exprimer must be prefilled at | þ | 1 ☐ Never Married 2X Married | Vas Decedent Ever in U.S. Armed Forces? □Yes 2 No fYes, Give /ear or Dates: | | Vas Decedent Yes, specify (☐Yes 2X | of Hispanic Orig Cuban, Mexican, No <i>Specify:</i> | gin? (Specify , Puerto Rica | Yes or No- in, etc.) | 14. Race Black, Specify: | White, e | etc. |
| 9500-61212 | within 72 hor iene. • than "natur the Medical I | Completed | 15. Decedent's Educatio (Specify only highest grade co Elementary/Secondary (0-12) | | (Give I life. E | ent's Usual Ookind of work do NOT use re | ne during most tired) | of working | | 16b. Kind of Business/Industry County Government | | |
| Maryland 2 | uld be filed Aental Hyg rked other tic event, | To Be C | 17. Father's Name (First, Middle, Last) Lewis Green 18. Mother's Name Nell 1 | | | | | | | _ | | |
| _ | as 1 and 2 should the of Health and Meni item 27 is market rother traumatic | | 19a. Informant's Name/Relationship (Type. Paul Massicot / Hust | 1 | | - | eet and Number en Driv | | | - | | |
| Baltimore, | permit. Pages 1:8 Department of He Important: If iten any Injury or oth once. | | 20a. Method of Disposition 1 ☆ Burial 2 ☐ Cremation 3 ☐ Remode 4 ☐ Donation 5 ☐ Other (Specify) | vai from State | lon Pa | sition (Name o natory or other Lrk Ceme | etery ' | March 2009 | 07, | c. Location - C | ore, | MD |
| Ball | permit. Depart Import any Inj once. | | 21. Signature of Funeral Service Licensee | nu | Ba 49 | Name and Active Name and Activ | Idress of Facility & Sons, Ritchie | , P.A. e Hwy, | Severi Severi | na Park na Park | Fun MD | eral Home 21146 |
| | Physician /Medical Examiner | | 23a. Pafr1. Enter the disease, or complications shock, or heart failure. List only one or immediate Cause (Final disease or condition resulting in death) | ons that caused the death. I use on each line. Chrocky Due to (or as a consequent | Br | er the mode of | | cardiac or re | spiratory arres | t, | _ | Approximate Interval Between Onset and Death |
| | cuted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequen | ice of): | | | | | | | |
| 8/60, | ficate be executed physician and s the burial-transit | dical Exa | resulting in death) Last | Due to (or as a consequen | ice of): | | | | | | | |
| O. Box 6 | ath certi attending for use a | Physician/Mec | in the past 12 months? | f yes, outcome of pregnanc; 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown | eath 3 | Ectopic pregr | | | | 23d. Date Mont | | ory Day Year |
| rds, r | quires that en signed l | <u>ج</u> | Part II. Other significant conditions contrib | uting to death but not resultir | ng in the un | derlying cause | given in Part I. | | | | | e cause of death? ably 4 ☐ Unknown |
| al Hecords | To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | Completed | | | | | | | 24a. Was an autopsy performe 1 □ Yes 2. | d? pri | ere autor or to cor ath?]Yes | osy findings available inpletion of cause of |
| VII | ystclan s certifi director | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hosp | ital: 1 ☐ Inpatient 2 ☐ ER | l/Outpatien | t 3 🗆 DOA | Othor: | | neck only one) 5 ☐ Residen | ce 6 10 Other | (Specifi | CE HOUSE |
| Ion or | nding Phy ath. r: After thi e funeral | ation: T | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | | 3b. Time of Injury | 28c. | njuryat Work? 1 □ Yes 2 □ N | 28d. | | injury occurred | | / |
| DIVISION | al or Atte s after de: al Directo | Certification: To | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 8e. Place of Injury - At home building, etc. (Specify) | e, farm, stre | eet, factory, offi | ce | 28f. | Location (Stre City or Town, | et and Number State) | or Rura | l Route Number, |
| | he Hospit in 24 hour he Funera ipletely filli | Medical (| | n: To the best of my knowle On the basis of examination and manner stated. | | | | | | | | |
|) | To t To t | D | 29b. Signature and title of certifier | eted cause of death (Item 2: 32. Registrar's Signature | | 29c. Lic | PC 8 1) | 6 | 290 | I. Date signed I | Month, I | Z MU 9 |
| | 100g | | 30. Name and address of person who comples of the state o | eted cause of death (Item 23 | 3a) (Type, F | Print) | カニ かい | An | n m | 2021 | 40, | 1 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) MAR U 5 2009 | St. Hegistrar's Signature | pa | What I | | | | | | |

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2009 **JAMES** M. MATTHEWS March 3:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Crisfield Alice Byrd Tawes Nursing Home 5. Social Security Number 6. Sex 7. Age (In Somerset If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Director 217-30-9756 73 May 29, 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3272 Sackertown Road 21817 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1**XO**Yes 2□ No **1**954**–** If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ Specify Specify White 3 Widowed 4 Divorced Year or Dates: 1976 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 US Army Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Matthews ပ Mamie Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3272 Sackertown Road - Crisfield, MD 21817

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Lois Matthews (Wife) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sunnyridae Memorial Park March 11, 2009 Crisfield, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death Day Year 5 Other (specify) P.0. 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by PARKINSONS DISEASE 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 After this certificate 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 8 ☑ No P 1 Inpatient 2 ER/Outpatient 3 DOA in 24 hours after death.

the Funeral Director: After thi
pletely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the I and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 48098 March 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** CHARLOTTE MILLER 2009 TARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner REGIONAL SALISBULY HIOMION MebICAL TENINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 □ F January 20, 1934 Virginia Director 214-30-8686 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macdical Examinar count to notified at 1 XYes 2 No Director Crisfield Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 531 W. Main Street - Apt. 203 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Alfred Pruitt Nelle Crockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Adkins (Daughter) 6963 Sandy Ridge Court - Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | March 12, 2009 Salisbury, Maryland 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. Signature of Funeral Service Thensee 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBLOUAS LULAR Physician DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ PNEUMON, A 2 → No 3 □ Probably 4 □ Unknown 1 ☐ Yes Be Completed WIANEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 4NO 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 100 62916 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 SOLITA OIVISION SUITEB SALISAURYMOZISOL 64MERREZ SUETLAMA

State Registrar 32. Registrar's Signature

MAR 1 0 2009

31. Date filed (Month, Day, Year)

Denne B. parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:30 A M Patricia B. Parker MARCH 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. Sept. 16, 1923 85 Yrs. Minnesota 472-22-3119 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar traust be notified at 1 Yes 2 □ No Prince George's Greenbelt Directo Mərylənd 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 United States 2L Research Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give 1944-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify. White δ ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Charts U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carl A. Blattman Minnie Castle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trau once. Linda H. Holden -Daughter 10314 Angora Drive Cheltenham, Maryland 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 3/5/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 ploneld 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory Insufficiency Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Severe Chronic Obstructive Lun: Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Supraventricular Arrythemia Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ρ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 K No 1 ☐Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 X No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Parker pathicia

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State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

06

Elizabeth Fasika, M.D. 8118 Good Luck Road Lanbam, Maryland 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D60925

29d. Date signed (Month, Day, Year)

2009

MARCH 5-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 0500 M PICCI RILLI 2009 WILLIAM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Crofton Convalescent Center Crofton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Days Hours Min. 1**X** M 2□ F 15, Pennsylvania 1930 78 Sep. 208-20-0367 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1X Yes 2 □ No Maryland Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20716 12730 Hoven Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jefferson Federal Elementary/Secondary (0-12) College (1-4or 5+) Savings & Loan Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelina DiNello Biagio Piccirilli ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12730 Hoven Lane Bowie, MD 20716 Helen M. Piccirilli/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 3/7/2009 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 XNo 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28h. Time of 28d. Describe how injury occurred 27. Manner of Death

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760, Physician/Medical signed by the a <u>P</u> 0 Division of Vital Records, <u>Ş</u> cate has been signated by page 2 should b Completed funeral director. Be this Certification: To To the Hospital or Autonomics within 24 hours after death.

To the Funeral Director: After the Funeral Director of the funeral by the funeral properties of the funeral proper

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

of 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Medical Evanturer must be notified at

Baltimore, Maryland 21215-0036

t and 2 should be in Health and M

Pages 1 ament of He

permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.

Physician

Examiner

/Medical

29a. Certifier

(Check only one)

Medical

State Registrar

5 Pending investigation 1 Natural 2 Accident 3 Suicide 4 Homicide

6 □ Could not be

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific

Parkway Annapolis

29d Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

end manner stated

2001 Medical stack 32. Registrar's Signature 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
State Registrar

Certificate of Death
1. Decedent's Name (First, Middle, Last)
2. Date of Death
3. Time of Death

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marier Experiment or other and many injury or other traumatic event, the Marier Experiment or other many injury or other traumatic event, the Marier Experiment or other many injury or other traumatic event, the Marier Experiment or other many injury or other traumatic event, the Marier Experiment or other many injury or other traumatic event, the Marier Experiment or other many injury or other traumatic event, the Marier Experiment or other many injury or other many injur

Baltimore, Maryland 21215-0036

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| Ethel | B. Rupper | t | | | | 3 | 7 | ^{ay} 200 | 09 | 3:05 | A M | | |
|---|-----------------------------|---|--------------------------------|-----------------------------------|--------------------------------|-----------------------------|---------------------------|-------------------------------------|--|----------------|----------------------------|---------------------------------------|------------|
| 4a. Facility Name | (If not institution, gi | ve street and number) | | 4b. | City, Town, o | Location (| of Death | | 4 | c. County of | of Death | | |
| | 4th St. | | | | | City | | | | Worce | | | |
| 5. Social Security 408-36- | | · 🗆 · · · • KI - | e (In yrs. last b 83 | | Inder 1 Year oths Days | If Under Hours | Min. | 8. Date of Bi (Month, D 12/21 | rth a <i>y 19ai</i> /10 2 | 35 | 9. Birthpl | lace (State try) | or Foreign |
| Usual Residence | | | 55 | | | | | 12/21 | / 152 | .0 | | 110 | |
| 10a. State | 10b. County | | 10c. City, To | wn or Location | 1 | | | | 100 | | 10 | d. Inside C | • |
| MD 10e. Street and N 746 94 11. Marital Status | Worces | ter | 0ce | ean Cit | у | | | | | | | 1 🖄 Yes | 2 □ No |
| 10e. Street and N | lumber | | | 10 | f. Zip Code | | | | 10g. C | itizen of W | hat Coun | try? | |
| 746 94 | th St. | | | 21842 | | | | | USA | | _ | | |
| 11. Marital Status | | 12. Was Decedent B Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) | er in U.S. | 13. Was E | ecedent of H , specify Cuba | lispanic Ori an, Mexicar | igin? (Spe n, Puerto F | cify Yes or N Rican, etc.) | 0- | | e - America k, White, e | | |
| | urried 2 Married 4 Divorced | If Yes, Give Year or Dates: | 10 | 1 □Y | es 2 XNo | Specify: | | | | Specify: | whi | te | |
| | 15. Decedent's E | ducation | 16 | ia. Decedent's | Usual Occup | ation | t of workin | 200 | 16b. | Kind of Bus | siness/Ind | lustry | |
| Elementary/Se | condary (0-12) | College (1-4or 5 | +) | life. DO N | OT use retired | dining mos d) | t or workin | ig | | | , , | - | |
| 12 | | | | Sales P | erson | | | · | | ail, | | <i>i</i> elry | |
| | e (First, Middle, Las | t) | | | | | | (First, Middle | e, maide | rı Surname | 9) | | |
| Lee Ba | | /Time Drints | | 9b. Mailing Ad | drage (Ctro-t | | | Alice | har Cir. | or Tour | State 7i- | Code | |
| | Name/Relationship | | | эь. машид Ас 35 Pine | | | | | | , | uaie, Zip | Joue) | |
| 20a. Method of D | | 3011 | | of Disposition tery, crematory | | | | ate | | _ocation - 0 | City or To | wn, State | |
| 1 🔀 Burial | | Removal from State | | et Mem. | Park | 3 | 3/12/ | 2009 | Ве | erlin | , MD | | |
| 21. Signature of | Funeral Service Lice | ensee | / | | me and Addre Willia | | | rbage rlin, | Fune MD 2 | ral 21811 | Home | | |
| 23a. Parv. Ente shock, or he Immediate Caus | eart failure. List only | nplications that caused one cause on each lin | ie. | | | | cardiac o | r respiratory | arrest, | | | Approxima Interval Be Onset and | tween |
| disease or condi resulting in death | ition | Due to (or as | | | CIANC | EV. | | | | | - | | |
| Sequentially list of if any, leading to | conditions, immediate | b Due to (or as a | a consequenc | e of): | | | | | | | | | |
| Cause (Disease that initiated ever | or injury | c | | | | | | | | | 15.1 | | |
| if any, leading to Cause (Disease that initiated ever resulting in death | n) Last | Due to (or as | a consequenc | e of): | | | | | | | | | |
| | | d | | | | | | | | | | - | |
| IF FEMALE: 23b. Was decede | ent pregnant | 23c. If yes, outcome | of pregnancy | ath 3□Ectr | opic pregnanc | :v | | | | | e of delive | - | V |
| in the past | 2 □No | 4 ☐ Pregnant at | | | er (specify) _ | , | | | | Mor | nth | Day | Year |
| 9 LJ Unknov | 1 | contributing to death bu | it not reculting | in the underly | ing cause cir. | en in Dart I | | 23e Did | tobacco | use contr | ibute to th | e cause of | death? |
| ` | imicant conditions | contributing to death bt | ar nocresuling | , in the unitelly | my cause giv | on in rait l | | | Yes | | Prob | | Unknown |
| | | | | | | | | - | | | | | |
| | | | | | | | | 24a. Was auto perl | opsy formed? | p | rior to cor leath? | psy findings npletion of | cause of |
| 25. Was case ref | ferred to medical | | | | | 26 Place | of Dooth | 1 ☐ Yes (Check only | - | lo 1 | □Yes | 2 □ No | |
| examiner? | No Thedical | Hospital: 1 ☐ Inpatie | ent 2 ⊟ ER/ | Outpatient 3 | DOA Oth | or: | ursing Hon | | _ | 6 □Othe | er (Snecifi | v) | |
| | eath | 28a. Date of Inju (Month, Da | ry 28b | Time of Injury | 28c. Inju | | | 28d. Describe | | | | · / | |
| 2 ☐ Accident | | on | ,, | Injury M | 1 1 🗆 | Yes 2□ | No | | | | | | |
| 3 ☐ Suicide 4 ☐ Homicide | 6 Could not l determined | | ury - At home, c. (Specify) | farm, street, fa | actory, office | | 2 | 28f. Location City or To | | | er or Rura | l Route Nur | nber, |
| 27. Manner of De 27. Matural 2 | | Physician: To the best of the basis of aminer: On the basis of and manner sta | f examination | | | | | | | | | | s) |
| 29b. Signature a | nd title of certifier | | | | 29c. Licens | e number | | | 29d. D | ate signed | (Month, i | Day, Year) | |
| • | Steple | ~ West | in ! | MO | 1 | san | 973 | 3 | | 3 | 3-9 | 1-0 | 37 |

Registrar

State

BA 6

1001 Philadelphia Ave. Ocean City, MD 21842

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Waters
31. Date filed (Month, Day, Year)
MAR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 4:15 2009 Ам March 8, <u>Oliver Eugene Reed</u> 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Locust Court Worcester If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Hours Months 10XM 2□ F 91 Nov. 11. 1917 236-01-1936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐XNo Maryland Worcester Berlin 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8 Locust Court 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 10 Yes 2 □ No If Yes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Operator Manufacturing 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) Oliver Ezra Reed Ella Strickland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Stover / Daughter Locust Court, Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/9/09 Frankford, DE Cape Henlopen Crem. 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William Street, Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hremio disease or condition resulting in death) Que to (or as a consequence of) Bore Marrow Failure Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

and

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. Medical Experies count to notified at once.

altimore, Maryland 21215-0036

the Maryland

/Medical

10a State

Examiner burial-tran attending physician for use as the buria Physician/Medical cate has been signed by the page 2 should be detached 9 Completed funeral director. Be filled in by the

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2**X**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number

BASTI

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

After this

after death.

e Funeral

within 24 ho

To the Fune

Division of Vital Records, P.O. Box 68760,

State Registrar

29d. Date signed (Month, Day, Year)

2009

ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

Berlin, MD 21811

. **Be**gistrar's Signature 31. Date filed (Month, Day, Yar) MAR 10 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 408 AM -2009 mara /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore QP Howard If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗷 F 219-04-9514 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Decartment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiment must be restitled at once. 1 □ Yes 2 No Director OY DOSI 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2190 USA Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married POSSAN / AITHNIT. ... Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Whit à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Lip Code) 19a. Informant's Name/Relationship (Type. Print) Deposit MD 20c. Location - City or Town, State LOVING athe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 🗖 Removal from State 3-6-2009 4 ☐ Donation 5 ☐ Other (Specify) Newark 22. Name and Address of Facility Strano + Feeley Family 21. Signature of Funeral Service License Funeral Home 635 Churchmans Rd. Newark neations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the disease, or communications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hea 10 Sh Physician (gum /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or selection exquestions of): the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) the 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2 XNo 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Figure 5 Home Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred Gunshat Self in file ted Gunshat Wound to hea 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation March 2, 2009 0468A 1 ☐ Yes 2 👿 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number of City or Town, State) 9 3 08 Howard Ave Edgemere Md 21219 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
BON FRIENDS RAS: CENC filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

VO

Trimble Hill CT. Lathervilla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Militello

10 2009

31. Date filed (Month Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

09099

| Physician |
|-----------|
| /Medical |
| Examiner |
| |

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Dire permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Phys /Me Exan

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

| | - | For State Registrar | State of Mic | ai yiaria 7 | | tificate of | Death | violitai i i | Reg. No. | 2009 | 09099 |
|---|-------------------|--|--|-------------------------|--------------------------------------|--|--|---------------------------------------|---|---------------------------------------|--|
| nysicia | in ' | 1. Decedent's Name (First, Middle, La RICHARD W. | RAY JR. | | | | | 2. Date of D Month MARCH | eath Day 6 | Year 2009 | 3. Time of Death 11:40P M |
| /Medic xamin | | 4a. Facility Name (If not institution, gi 6001 Muncaster M: | ve street and number) | sey Hou | ıse | | or Location of Death | 1 | 4c. | County of Death Montgon | nery |
| neral ector | | Social Security Number 6. | | e (In yrs. last i 46 | | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, L | irth Pay, Yea <i>r)</i> 15 19 | Coui | place (State or Foreign ntry) aryland |
| 8a-f show | ector | Usual Residence of Decedent 10a. State 10b. County Md • Montg | omery | 10c. City, To | | cation Spring 10f. Zip Code | | | 10a Citi | izen of What Cou | 10d. Inside City Limits 1 □Yes 2 🖪 No |
| 23a or 2 | Funeral Director | 10e. Street and Number 12112 Dewey Ro | ad | | | | 20906 | | | United S | States |
| Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be rediffed at once. | | 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 □ Yes 2 M If Yes, Give Year or Dates: | No | | I∐Yes 2 1 No | | pecify Yes or No Rican, etc.) | | | etc. White |
| an "natur Medical | Completed by | 15. Decedent's Elementary/Secondary (0-12) | Education rade completed) College (1-4or 5 | | (Give life. l | OO NOT use retire | during most of world) | rking | | ind of Business/In | |
| d other th event, the | Be | 17. Father's Name (First, Middle, Las Richard W. | | | Mal | .ntenance | 18. Mother's Nar | _ | | Surname) | <u></u> |
| 7 is marke traumatic | 은 | 19a. Informant's Name/Relationship Erin C. Ray | | 1 | | ng Address (Street | t and Number or R | | aber, City o | or Town, State, Zi | p Code) 20906 |
| nt: If item 27 rry or other I | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spec | ☐ Removal from State | I | e of Dispo etery, crer | sition (Name of natory or other pla itan Cre | ace) | Date 8/09 | | exandria | own, State , Virginia |
| Importa any inju once, | | 21. Signature of Funeral Service Lice | Barlie | | | P. O. F | H. Barber Box 5038, | Layton | svill | ne Le, Md. | 20882 Approximate |
| sician edical miner | | 23a. Part 1. Enter the sease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) | y one cause on each li GAS' | TRIC CA | ANCEF | | ing, such as cardia | c or respiratory | anest, | | Interval Between Onset and Death |
| physician and the burial-transit | al Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C | | | | | | | | | |
| D & | Physician/Medical | d | | | | | | | 23d. Date of delivery Month Day Year | | |
| signed by the d be detached | þ | 9 ☐ Unknown Part II. Other significant conditions | 9 ☐ Unknown contributing to death l | out not resultin | ng in the u | nderlying cause g | iven in Part I. | | d tobacco | | the cause of death? |
| ate has beer page 2 shoul | Completed | | | | | | | 24a. Wa au pe 1 □ Yes | topsy rformed? | prior to c death? | topsy findings available ompletion of cause of |
| s certific director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpat | ient 2 ☐ ER | ₹/Outpatie | nt 3 □ DOA O | 26. Place of Dether: 4 ☐ Nursing | | | 6 Other (Spec | Hospice |
| To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use | Certification: T | 27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homlcide 5 Pending investigat 6 Could not determine | be 28e. Place of Ir | ay, Year) | Bb. Time of Injury e, farm, st | Wo | □Yes 2□No | | | nd Number or Ru | ral Route Number, |
| e Funeral letely fille | Medical C | 29a. Certifier (Check only one) 1 Certifying 2 Medical Ex | Physician: To the best aminer: On the basis and manners | of examination | edge, dea n and/or i | th occurred at the nvestigation, in my | time, date and place opinion, death occ | ce, and due to t curred at the tim | the cause(s | s) and manner as nd place, and due | stated. to the cause(s) |
| To th comp | Me | 29b. Signature and title of certifier Docellyne | Koueltel | reu, | mj | | nse number 363748 | | | ate signed (Month March 8, | |
| ٥ | | 30. Name and address of person with JOCELYNE KOUAT | no completed cause of CHOU, M.D. | death (Item 2 | 3a) (Type 001 M | Print) UNCASTER | MILL ROA | AD, ROCE | KVILL: | E, MD. | 20855 |
| Sta Regist | ate rar | 31. Date filed (Month, Day, Year) | JI/ | trar's Signatur | | Bon May | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 730 M F. Richardson March Lester /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HICPATO REGIONAL MEDICAL SALISBURY Center TENINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 7-15-1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Months Hours 1**X** M 2□ F 76 Maryland Director 214-30-7817 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Pittsville MD Wicomico 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21850 USA 34716 Tingle Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 195
If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1956-1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White <u>ک</u> Specify: 1963 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Self Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental 7 is marked o Edith Richardson Donaway ည Isaac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 34716 Tingle Road, Pittsville, Maryland 21850 <u>Mary Lou Richar</u>dson - Wife other permit. Pages 1 a
Department of Hes
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pittsville Cemetery 3-7-2009 Pittsville, Maryland Mature Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chrouic obstruction line disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O, Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 2 No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 ☐ Yes 2 (No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1.₩Naturai 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Invilue / loacure mo 7 32014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Majory Moduldua and 106 initioned st Soy 15 Sulichery and 21804

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2009 **Physician** 6:30 p M Olivia P. Russell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Severna Park 613 Pin Oak Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15, 1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Maryland 1 □ M 2**X** F 219-16-0226 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2 1 No Director Severna Park Anne Arundel MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number with 1 21146 USA 613 Pin Oak Road items 23a Funeral 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 White 1 ☐ Yes 2X No Specify Specify: ð 3 ₩ Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Homemaker **Home** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Rebecca Paxton Thomas Hinton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13609 Skyview Terrace Mount Airy, MD 21771 of Health Bonnie Wilson/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of 4, Department of Important: If its any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Faperal Service Severna Park Funeral H Severna Park, MD 21146 Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. P.A. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death adenocavcinoma of vuknown Avimavy Immediate Cause (Final 2 mouter **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation after death.

I Director: Af in by the full 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

completely

State Registrar 29a, Certifier

(Check only

31. Date filed (Month,

29b. Signature and title of certifier

Day, Year)

MAR 05 2009

Bestgate Rd. Suite 300 Annapolis, Md. selonich, mo 900

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0

| | | - | State Registrar | | Certificate of E | Death | Reg | g. No. | |
|------------|---|-----------------|---|--|--|--|--|--|---|
| | Physicia /Medic | | 1. Decedent's Name (First, Middle, Last) Patrick J. Rhode: | 5 | | | 2. Date of Death Month March | 1 2009 Pay | 3. Time of Death 4:14 P M |
| | Examin | | 4a. Facility Name (If not institution, give stre 874 Childs Point Ro | et and number) ad | | polis | | | rundel |
| | Funeral Director | | | 7. Age (In yrs. last bit | rthday) If Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, Aug 23, | Year) Cou | place (State or Foreign ntry) ington D.C. |
| | e Maryland 8a-f show | Director | Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun | del Anna | polis | | | | 1 Grant State City Limits |
| | with the | I Dire | 10e. Street and Number 874 Childs Point Ro | ad | 10f. Zip Code 21401 | | 10 | g. Citizen of What Cou United Sta | |
| 5-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Itemical Exeminar must be notified at once. | by Funeral | 11. Marital Status 12. 1 □ Never Married 2 ※ Married | Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates: WWII | 13. Was Decedent of His If Yes, specify Cubar 1 □ Yes XX No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Ameri Black, White, Specify: Wh | can Indian, etc. |
| 0-6171 | vithin 72 ho ene. Ihan "natur e Nedical | Completed | 15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4or 5+) | a. Decedent's Usual Occupa (Give kind of work done dilife. DO NOT use retired) Realtor | ition uring most of work | ing | 6b. Kind of Business/Ir Real-esta | · |
| 0 | filed v I Hygie other i | Be Co | 17. Father's Name (First, Middle, Last) | | Realtor | 18. Mother's Name | (First, Middle, Ma | | LE |
| /land | uld be Menta arked atic ev | To B | Henry F. Rhodes | | | | te Baill | | |
| Mar | 12 sho th and 7 Is ma trauma | | 19a. Informant's Name/Relationship (Type. Denise L. Bonner / | · | b. Mailing Address <i>(Street a</i> 02 Creek Driv | | | | |
| ف | s 1 and of Healt ltem 2 other | - 50 | 20a. Method of Disposition | 20b. Place o | of Disposition (Name of ery, crematory or other place | | | Oc. Location - City or T | |
| Бащтог | mit. Page partment o sortant: If / Injury or 2e. | | 1 ☐ Burial XX Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses | noval from State | ore Crematory | 3/4/2 | | altimore, l lor Funera | Maryland 1 Home, Inc. |
| ă | Deparmi Impo any Ir | 10 | remid of & | sam | 147 Duke of | Glouces | ter St. | Annapolis, | MD 21401 |
| | Physician /Medical | | 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one disease or condition resulting in death) | ions that caused the death. Do cause on each line. Due to (or as a consequence | e | | | | Approximate Interval Between Onset and Death |
| | Examiner | ical Examiner | Sequentially list conditions, it ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d | Due to (or as a consequence | diovascle | (e < 1) | 7 Sels | 2 | , |
| B | death e atter d for u | ysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown | | , | _ | 23d. Date of deli | very Day Year |
| ds, P. | requires that the peen signed by th hould be detache | d by Phy | Part II. Other significant conditions contri | outing to death but not resulting | in the underlying cause give | en in Part I. | | acco use contribute to | 17 |
| Yes Yes | The law req ate has beer page 2 shou | Completed | | | | | 24a. Was an autopsy perform 1 □ Yes 2 | prior to c | opsy findings available ompletion of cause of |
| Vital | Physiclan: r this certific ral director, p | Be | 25. Was case referred to medical examiner? | pital: | Othe | Vr. | h (Check only one | | |
| o | g Phys er this eral dir | n: To | 27. Manner of Death | 28a. Date of Injury 28b. | Time of 28c, Injury | 4 □ Nursing Ho | ome 5 Resider 28d. Describe how | nce 6 Other (Spec w injury occurred | ify) |
| DIVISION | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page | Certification: | 1/≦Natural 5 | (Month, Day, Year) 28e. Place of Injury - At home, f building, etc. (Specify) | M 1 🗆 ' | r Yes 2 □ No | 28f. Location (Str. City or Town, | eet and Number or Rui State) | ral Route Number, |
| _ | Hospital 24 hours a Funeral C | Medical Ce | | ian: To the best of my knowledgr: On the basis of examination a | | | | | |
| . | To the within ; To the comple | Mec | 29b. Signature and title of certifier | 2002 | 29c. License | number | 29 | d. Date signed (Month | , Day, Year) |
| , | 1×, 3 | 1 | 30, Name and address of person who com | poleted allow of eath (Item 23a) | (Type, Print) | of Divi | e Glen | Bningh | 1.2106) |

Registrar

MAR 0 4 2009 Lives S. Sansture

| ame 09-0 Reg | nd lin 1958 jina Ross | е | 22 per fd aaco hlth dept 3/16/(Please Type or Print in Black Indelible State of Maryland / Department |)9 dlw Ink. Ensur of Health ar | r e All Copie nd Mental Hy | s Are Legi /giene | ble. 2005 | 0910 | | | | |
|--------------------|--|----------------|---|--|---|---|---|------------------------------|--|--|--|--|
| | | | 1- For State Certificate Registrar | | | Reg | No. | | | | | |
| Ma | Physicia dical Exami | 41.1/ | 1. Decedent's Name (First, Middle,Last) | | 177 | 2. Date of Death Month [| Day Year | 3. Time of Death 2112 hrs | | | | |
| WIE | ulcai Exami | Hei | Regina Ross 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, o | r Location of Death | March 8, 20 | 4c. County of Death | 21121110 | | | | |
| (| | | Baltimore Washington Medical Center Glen Burnie Anne Arundel | | | | | | | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) |) If Under 1 Ye Months Da | | 1 . | (MM/DD/YYYY) 9. Birt Foreig | n | | | | |
| | Director | | 217-58-1826 1 M 2XF 57 | Yrs. | | Jan 2 | 3 1952 94 | !arryland | | | | |
| | any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits | | | | |
| 1 | Aaryland 28a-f show 1 at once. | ٥ | Maryland Anne Arundel Glen | Burnie | | | | 1 Yes 2 X No | | | | |
| 10 | Maryl r 28a-f | rector | 10e. Street and Number | 10f. Zip Code | | 10g | . Citizen of What Cour | itry? | | | | |
| Vi | death with the Maryland or items 23a or 28a-f sho must be notified at once | al Dir | 309 Apt T-2 Oak Manor Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13. | Was Decedent of H | 061 | ecify Yes or No- | USA 14. Race - Americ | can Indian Black | | | | |
| | eath w items | Funeral | 1 X Never Married 2 Married Armed Forces? | If Yes, specify Cuba | an, Mexican, Puerto | Rican, etc.) | White, etc. | san malan, block, | | | | |
| | after d al", or | by Fu | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | Yes 2 X N | | | | ack | | | | |
| | hours after 'natural", Examiner | ted t | | dent's Usual Occup g most of working lif | | | 6b. Kind of Business/I | ndustry | | | | |
| | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once | mpleted | 10th 0 | Bus Dr | iver | | Providenc | e Center | | | | |
| | 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | ပိ | 17. Father's Name (First, Middle, Last) | | 18.Mother's Name | | | | | | | |
| | 121 Id be fi Aental narked event, | о Ве | Leonard W. Ross Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Ma | iling Address (Stre | | Ly V. He | er, City or Town, State | Zin Code) | | | | |
| | AD 2 2 shou 1 and N 27 is n matic | To | | · · | | | oolis, Md | | | | | |
| | more, I Pages I and rent of Health int: If item | 7 | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory of | position (Name of c | | | 20c. Location - City or | | | | | |
| | Pages nent of ant: I | | Memori | al Garde | ens 3- | 14-09 | | | | | | |
| | Baltimore, MD permit Pages 1 and 2 shc Department of Health and Important: If item 27 is injury or other traumati | | land id bl | Miname an Rose | seff litySon | s Mort | uary, P.A s, Md. 21 | • Mortuary | | | | |
| | Physician | | 2 a. Part I. E. ter the disease, or complications that caused the death. Do not ent | | | | | Approximate Interval | | | | |
| | /Medical | 9. 3 | failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine intoxicati | .on | | | | Between Onset and Death | | | | |
| 100 | xaminer | | or condition resulting in death) Due to (or as a consequence of): | | | C DC | | 8 10 | | | | |
| | | er | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | |
| | | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in (earth set | - | | | | | | | | |
| | executed an and al - transit | | d. | | | | | | | | | |
| | Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra | sician/Medical | X UNPENDED AMENDED 23a,27,28a-f | , perME, | g889 3/2 ² | +/09 TT | | | | | | |
| | Box 68760 e death certificate b the attending physical for use as the bu | n/Me | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth | Fetal death 3 | Ectopic pregna | incv | 23d. Date of delivery Month |) Day Year | | | | |
| | X 68 th certi ttendir r use a | icia | past 12 months? 4 Pregnant at time of death 5 | Other (Specify) | | | | , | | | | |
| | . Bc the dea y the a | Phys | 1Yes 2No 9 | he underlying cause | oiven in Part I. | 23e. Did tob | acco use contribute to | the cause of death? | | | | |
| | of Vital Records, P.O. B g Physician: The law requires that the d ther this certificate has been signed by the meral director, page 2 should be detached | ρ | Takin. Stiller significant containors | ne and onlying cadac | , given in raici. | | 2 No 3 Prob | | | | | |
| | ords, w require us been si should b | Completed | | | | 24a. Was ar | | topsy findings available | | | | |
| | ecol he faw te has ige 2 sl | ldmo | | | | perform | ned? death? | , | | | | |
| | Vital Reco ysician: The law his certificate has director, page 2 s | Be Co | 25. Was case referred to medical | 26.Pla | ce of Death (Check | | | | | | | |
| | Vita hysici r this c | To B | examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpat | | | | esidence 6 Other | 1 | | | | |
| | n of Niding Phy. | | 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending F1 2 / 9 / 00 F1 9 9 | 1 1 | jury at Work? Yes 2X No | unk | w injury occurred | | | | | |
| | Division tal or Attendir as after death. "al Director: A led in by the fu | icati | 2 Accident Investigation Fd 3/8/09 Fd 8: 28e. Place of Injury - At home, farm, | street, factory, office | | | reet and Number or Ru | ral Route Number, City | | | | |
| | Div oital or ours after rral Di | Certification: | 3 Suicide 6 X Could not be determined (Specify) found: resi | dence | - | or Town, Sta | _{ite)} 309 Oak I Glen Burn: | lanor Dr. ie, MD | | | | |
| | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical C | 29a. Certifier (Check ority one) 2 Medical Examiner: On the basis of examination and/or inves and manner stated. | ccurred at the time, tigation, in my opinion | date and place, and on, death occurred a | due to the cause at the time, date a | (s) and manner as statend place, and due to the | ed. e cause(s) | | | | |
| | To with To | Me | 29b. Signature and title of certifier | 1 | nse number | | 29d. Date signed (Mo | nth, Day, Year) | | | | |
| | | | hylli, neis | 0.0 | C.M.E. | | March 9, 2009 | | | | | |
| • | _ | | 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn St | treet, Baltimore | , MD 21201 | | | | | | | |
| | s | tate | | | | | | | | | | |
| | Regis | trar | MAR 1 6 2009 32. Registrar's Signature | - arrive | | | · · · · · · · · · · · · · · · · · · · | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death Month 3 Day **Physician** 2009 12:00 P™ Mary Ann Stankus 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 48 Anchor Way Berlin Worcester Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 6/5/1931 **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 77 115-26-2970 Director NY Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Exprinter must be notified at Director 1 ☐ Yes 2 ☑ No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 48 Anchor Way 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 Married 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ∐Yes 2 X No Specify Q, Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) Accountant Research Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be George Armaganian Aune Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. Robert Stankus / husband 48 Anchor Way, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Cape Henlopen Crem. 3/9/2009 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 21. Signature of Funeral Service L 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a const uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Entire Unioning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown cate has been si page 2 should I Completed 24a. Was an autopsy performed? 1 □Yes 2 □No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenc within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not he 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical юmpletely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NE Date filed (Month, Day, Year) 32. Registrar's Signature State

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32. Registrar's Signature

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Suit #3

ELLTUN MAKYLAWO aMal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIN GHY-EL

31. Date filed (Month, Day, Year)

304-306

State of Maryland / Department of Health and Mental Hygiene. U For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** Рм 1:15 March 2, Paul George Suchoski /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F 166-26-3034 75 Director December 1, 1933 New Brighton, PA Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examinar rount be notified at 1 X Yes 2 ☐ No Maryland | Prince George's Cheverly Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 20785 USA 3010 Crest Avenue or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. All XI Yes 2 □ No
If Yes, Give
Year or Dates: 1953–1961 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) National Security Agency Engineer 5+ other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be it of Health and Mental Paul Braddock Suchoski Agnes Fairbanks ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Suchoski / Son 4266 Solomons Island Rd., Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or Metropolitan Crematory 3/7/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue (4) RAY Cogen Gasch's Funeral Home, P.A. Hyattsville, MD 20781 9 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) 3 Months /Medical Due to (or as a consequence of) Examiner Non-obstructive Coronary Artery Disease 3 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 Ventriculoperitoneal Shunt 1 Yes 2 No 3 Probably 4 MUnknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Parkinsons Disease 24a. Was an autopsy performed? certificate 2 🔯 No 1□ Yes or Attending Physicien: 25. Was case referred to medical funeral director, Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural Injury 5 Pending 1 Yes 2 No death. investigation 2 Accident the t Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 D16273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy, 6130 Landover Road, Cheverly, MD 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) parker State Registrar MAR 0 9 2009

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 9

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

| | • | For State Registrar | State of | ıvıaı yıarı | | Certificate of | | vientai ny | Reg. No. | 2009 | 09107 |
|---|---|--|---|---------------------------------------|-----------------|--|---------------------------------------|-------------------------------------|--|---------------------------|--|
| Physicia | | 1. Decedent's Name (First, Midd NORMAN STEWAR | | | | | | 2. Date of De Month FEBRUA | | 5, 2009 | 3. Time of Death 2:27P M |
| /Medic | | 4a. Facility Name (If not institution | | ber) | | 4b. City, Town, o | r Location of Death | | | County of Deat | |
| -xaiiiii | C1 | 6514 MIDRA DR | IVE | | | LAN | HAM | | PR | INCE GE | ORGES |
| uneral irector | | 5. Social Security Number 082 48 4896 | 6. Sex 7 | . Age (In yrs. la | st birthe Y | I Months I Davs | If Under 24 Hrs. Hours Min. | 8. Date of Bi (Month, D APRIL | rth <i>ay, Year)</i> 12 , 1 | Co | thplace (State or Foreign untry) MAICA |
| M | | Usual Residence of Decedent 10a. State 10b. Count | / | 10c. City | , Town o | or Location | | | | | 10d. Inside City Limits |
| f sho | ō | | E GEORGES | TAT | NHAM | r | | | | | XXYes 2 □ No |
| -28a- | Director | 10e. Street and Number | GEORGES | LAI | VILETTI | 10f. Zip Code | | | 10g. Citi: | zen of What Co | untry? |
| 3a or | | 6514 MIDRA DR | T V E | | | 2 | 0706 | | UN | ITED ST | ATES |
| r | Funeral | 11. Marital Status | 12. Was Deced Armed Force | | S. | 13. Was Decedent of H If Yes, specify Cub | Hispanic Origin? (Span Mayican Puerto | pecify Yes or N | 0- | 14. Race - Ame | |
| Department or really and wenter registers. The partment or really and waste and the mass are show any injury or other traumatic event, the Medical Evaluation is ust be notified at once. | by | 1 ☐ Never Married ②XXMa 3 ☐ Widowed 4 ☐ Divorce | rried 1 ☐ Yes X | K No | | 1 □Yes XX No | Specify: | o Thoan, 60., | | Black, White | LACK |
| hatu | etec | | nt's Education est grade completed) | | - (| Decedent's Usual Occup Give kind of work done | during most of work | king | 16b. Kir | nd of Business/ | Industry |
| han " | Elementary/Secondary (0-12) College (1-4or 5+) | | | | | | | | | | |
| ther t | | 12TH 17. Father's Name (First, Middle | Last) | | W | AREHOUSE W | 18. Mother's Nam | ne (First, Middle | | PRIVATE Surname) | |
| c eve | o Be | ă | | | | | | | | | |
| mar! | UNK • MARIAM MOULTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | Zip Code) | |
| 27 is | | DAPPLE JOHNSO | N/WIFE | | 651 | 4 MIDRA DR | IVE LA | NHAM, N | 1D 20 | 706 | |
| item | | 20a. Method of Disposition | | 00 | ace of E | Disposition (Name of | | Date | 20c. Lo | cation - City or | Town, State |
| ant: If | **XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WASHINGTON NATIONAL CEM. 3/14/09 SUITLAND, | | | | | | | | MD | | |
| Importa any inju | | 21. Signature of Euneral Service | | DR. G | | 22. Name and Addre MARSHALL 4308 SUIT | ss of Facility S FUNERAL | HOME (| OF MA | RYLAND, MD 20 | INC. |
| | | 1 / | <u> </u> | used the death | | | | | | , IID_20 | Approximate Interval Between Onset and Death |
| /sician ledical | | Immediate Cause (Final disease or condition resulting in death) | | CARDIC r as a consequ | | CULAR DISE | ASE | | | | |
| aminer | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b | r as a consequ | ence of |): | | | · | | |
| ind transit | Examiner | Cause Clies or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| physician and s the burial-transit | | resulting in death) Last | Due to (o | r as a consequ | ence of |): | | | | | |
| O) (C) | /ledical | | | | | | | | | | |
| within 44 hours after to teach. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use. | ıysician/∧ | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown | | rth 2 Fetal | death | 3 | су | | 2 | 23d. Date of del Month | livery Day Year |
| ned b deta | by Phys | Part II. Other significant condi- | tions contributing to dea | ith but not resu | Iting in t | the underlying cause given | ven in Part I. | 23e. Did | tobacco u | se contribute to | the cause of death? |
| en sig uld be | 요 | | | | | | | 1 🗆 | Yes X | XNo 3□ Pr | robably 4 🗆 Unknown |
| te has bee age 2 sho | Completed | | | | | | | per | s an opsy formed? | prior to death? | utopsy findings available completion of cause of |
| rtifica tor, p | Be C | 25. Was case referred to medic | al | | | | 26. Place of Dea | | | I les | 2 🗆 140 |
| direc | | examiner? 1 ☐ Yes ※※ No | Hospital: 1 ☐ In | patient 2 🗌 | ER/Outp | oatient 3 DOA Oth | ner: 4 🗆 Nursing H | lome XX Res | sidence 6 | 6 □ Other (Spe | ecify) |
| tin. r: After the e funeral | ation: | 27. Manner of Death XX Natural 5 ☐ Pend 2 ☐ Accident inves | 28a. Date of (Month tigation | f Injury , <i>Day, Year)</i> | 28b. Tir Inj | ury Woi | ryat rk?]Yes 2 ∐No | 28d. Describe | how injury | y occurred | |
| I Directored in by the | Certification: To | 3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter | mined 200. Place C | of Injury - At ho g, etc. (Specify | me, farn | n, street, factory, office | | | (Street and own, State, | | ural Route Number, |
| e Funera | Medical (| | ing Physician: To the tall Examiner: On the ball and manner | sis of examina | | | | | | | |
| То t | Me | 29b. Signature and title of certif | er | | | 29c. Licens | se number | | 29d. Dat | e signed (Mont | h, Day, Year) |
| 5 | | 1/20/0 | 10-5-Da | 0 | | 146 | 6665 | | 03 | 106/2 | 7009 |
| 8 | | 30. Name and address of person | n who completed cause | of death (Item | 23a) (T | ype, Print) ACC + S | He 200 | LA129 | OM | D 207 | 74 |
| Sta Registr | | | | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

| | | - | For State Registrar | State of Ma | ryland / Dep | | Health and I | Mental Hy | _ | 09108 | |
|--|--|---|---|---------------------------------------|----------------------|---|--|---|---|---|--|
| | Physicia /Medic | al | 1. Decedent's Name (First, Middle, Las Karl U | oton Schm | | | | 2. Date of Dea Month March | Day Year 5, 2009 | 3. Time of Death 7:26 P. M | |
| · de | Examin | | 4a. Facility Name (If not institution, give street and number) Heartland Health Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | | | | 4b. City, Town, or Location of Death | | 4c. County of Death | | |
| A No. | | | | | | Hyattsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Days | | | Prince Georges 9. Birthplace (State or Foreign | | |
| | Funeral Director | | | X M 2□ F | 75 Yrs. | Months Days | Hours Min. | (Month, Da August | 19,1933 Was | intry) | |
| Maryland 2121 | yland | | 10a. State 10b. County | | 10c. City, Town or L | ocation | - | | | 10d. Inside City Limits | |
| | e Mar la-fs | Director | Maryland Prince (| Prince Georges Hyattsville | | | | | | 1 X Yes 2 □ No | |
| | 72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Exaction must be notified at | Dire | 10e. Street and Number | | | 10f. Zip Code | 0.0 | | 10g. Citizen of What Cou | | |
| | | To Be Completed by Funeral | 6500 Riggs Road | 40 14 Dd | | 2078 | | posify Voc or No | United Sta | | |
| | | | 11. Marital Status 1 | | | J.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F | | | an, etc.) Black, White, etc. Specify: White | | |
| | hour | | 15. Decedent's Ed | | 16a. Dec | edent's Usual Occu | pation | | 16b. Kind of Business/Ir | ndustry | |
| | s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, its MM. | | (Specify only highest grade completed) (Give kilife. DC | | | kind of work done during most of working CO NOT use retired) Announcer & Messenger | | | Western Union | | |
| | | | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | ne (First, Middle, | Maiden Surname) | | |
| | | | Walter H. Schmidt | | | Noka Faustine | | | ne Upton | Upton | |
| | | | 19a. Informant's Name/Relationship (| | | | | | er, City or Town, State, Z | | |
| | | | Attorney Caroline | e Wills(Gu | | | | | | | |
| Baltimore, | | | 20a. Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery 20c. Location - City or Town, State Suitland, Maryland | | | | | | | | |
| Balti | permit. Page Department of Important: If any Injury or | | 21. Agnature of Fineral Service Liberts 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, | The deam certificate be executed The attending physician and the attending physician and the purial-transit the for use as the burial-transit the physician and the physician | Completed by Physician/Medical Examiner | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to hinter district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cardiorespiratory Arrest Due to (or as a consequence of): Cerebrovascular Accident Due to (or as a consequence of): Atherosclerosis Cardiovascular Disease Due to (or as a consequence of): Hyperlipidemia | | | | | | | | |
| | | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | ☐ Ectopic pregnancy ☐ Other (specify) | | | 23d. Date of deli Month | 23d. Date of delivery Month Day Year | | | |
| | uires that the de n signed by the a Id be detached f | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Encephalopathy | | | | | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐒 Unknown | | | |
| | or Attending after death. Director: After in by the funer | | Chronic Obstru | | | ease | | 24a. Was autor perfo | | topsy findings available completion of cause of | |
| | | | Congestive Heart Failure | | | | | 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No | | | |
| | | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No | | | | | Death (Check onl one) ing Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| | | 12 | 27. Manner of Death | 28a, Date of Injury 28b, Time of 28c, | | | ury at | 28d. Describe how injury occurred | | | |
| | | al Certification: To | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b | n M | | M 1 E | Work? 1 □ Yes 2 □ No ##ice 28f. Location (8 | | Street and Number or Rural Route Number, | | |
| | | | 4 Homicide building, etc. (Specify) City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | s stated. | |
| | To the Hospital within 24 hours a To the Funeral completely filled | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the officer tilifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | | |
| | F 5 F 0 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | , 2009 | | | |
| | | | Oney Zuniga, M.D | .; 4701 Ra | indolph Ro | ad; Suite | 216;Rock | ville, | Maryland 208 | 352 | |

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SR. 2009 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1⊠M 2□ F -78-A533 5-19 Director lorida Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be nettined at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ⊠Yes 2 □ No Funeral Director MARY AND Wicomico : Sbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 609 BOOT 21801 REE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NEILIE UNKNOWN NAE venish ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Dwight ShivERS HARANIE GEN BURNIE, Mel 2106 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -09 Salis bury 4 □ Donation 5 □ Other (Specify) LREMATORY! 2 Name and Address of Facility 21. Signature of Funeral Service Licensee DAVIG. M-FUNGRA Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** FORTIC OCCCUSION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dilateral Lower Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Ute Kenal and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 T Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 🔼 No 3 Probably 4 Unknown in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has performe certificate 1 ☐ Yes 2 DiNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No death. after death 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 19076 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SY BALTIMORE Year) 31. Date filed (Month, Day, State Registrar

09-01697 Donald Skinner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| | 6 | 2 | 0 | 0 | 9 | | 0 | 9 | | l | |
|--|---|---|---|---|---|--|---|---|--|---|--|
|--|---|---|---|---|---|--|---|---|--|---|--|

| | | For State | | Certificate o | f Death | | Red | . No. | |
|---|----------------|---|--|--|--|----------------------------|--|---|---|
| Physicia ledical Exami | in/ | Decedent's Name (First, Middle | _{Last)} lark Skinne | r | | J.Fro. | 2. Date of Death | Day Year 7, 2009 | 3. Time of Death 0830 hrs |
| | | 4a. Facility Name (if not institution Peninsula Regional Me | = | | 4b. City, Town, or L Salisbury | ocation of Death | | 4c. County of I Wicomico | Death |
| Funeral Director | | 5. Social Security Number 202-52-1866 | 6. Sex 7. Age (I | n yrs. last birthday) L | If Under 1 Year Months Days s. | If Under 24Hrs. Hours Min. | 8. Date of Birth | 9. Birthplace (State or Foreign Country) Pennsylvania | |
| and show any. <u>nce.</u> | _ | Usual Residence of Decedent 10a. State 10b. County Maryland Wico | | c. City, Town or Loca | | | | | 10d. Inside City Limits 1 Yes 2 X No |
| th the Maryla 23a or 28a-f. notified at or | Director | 10e. Street and Number 6320 Rockawa | lkin Road | | 10f. Zip Code 21801 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc) 1 Yes 2 X No specify: | | | g. Citizen of What USA | t Country? |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland it and Menda Hygieine. 27 is marked other than "natural", or items 23a or 28a-f she armine event, the Medical Evaniner must be notified at once | by Funeral | | orced If Yes, Give Year or Dates: | No If | | | | White, | vhite |
| 136 thin 72 hours ne. than "natur edical Exam | Completed | 15. Decedent's Education (Spec Elementary/Secondary (0-12) 12 | dary (0-12) College (1-4 or 5+) 5+ | | 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retirements of the architect | | | archit | |
| Baltimore, MD 21215-0036 permit Pages t and 2 should be filed within 72 Department of Health and Mental Hygiène. Imporéant: If item 27 is marked other than "nijury or other traumatic event, the Medical | Be | 17. Father's Name (First, Middle, Dale Dean Ski | nner | 10b Meili | ng Address (Street | | runinge | c | State Zin Code) |
| e, MD 2 and 2 shoul teafth and M item 27 is m traumatic | 은 | 19a. Informant's Name/Relationsh Bridget Skinn 20a. Method of Disposition | er/wife | 6320 20b. Place of Dispo | O Rockawa | lkin Rd. | , Salis | oury, MD | 7 |
| Baltimore, permit: Pages I an Department of He. Important: If ite | | 1 X Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service | ecify: | Garden: | | - 7 | 5/09 | | urnie, MD |
| Physician /Medical | | 23a. Part I. Enter the disease, or failure. List only one cause | on each line. | e death. Do not enter | the mode of dying, | Hill Rd | , Salis | st, shock, or hear | nal Association 21804 t Approximate Interval Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. Atherosclerotic Conductor Due to (or as a consequence) | | sease | | | 1 | Deali |
| ited d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consequence) Due to (or as a consequence) | | | 4141 | X | | |
| Box 68760, c death certificate be executed the attending physician and cd for use as the burial - transit | /Medical | UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | I Live Ditti | 2 F | Fetal death 3 [| Ectopic pregna | ancy | 23d. Date of d Month | lelivery Day Year |
| P.O. Box 687 that the death certific ned by the attending I detached for use as th | / Physicia | 1 Yes 2 No 9 Univ | known 4 Pregnant at tir g Unknown ions contributing to death b | J | Other (Specify) | iven in Part I. | | | oute to the cause of death? |
| S 15 S | Completed by | | | | | | 24a. Was autop | an 24b. W sy pr med? de | Probably 4 V Unknown Vere autopsy findings available ior to completion of cause of eath? |
| Vital Rec ysician: The l his certificate director, page | | 25. Was case referred to medica | | | 26 Place | of Death (Check | 1 Yes | 2 No 1 | Yes 2 No |
| Vita hysician this cer | o Be | examiner? 1 ✓ Yes 2 No | I to a selection of | 2 🗸 ER/Outpatie | | Other | | Residence 6 | Other: |
| Division of Vital Records, tal or Attending Physician: The law requir as after death. In Director: After this certificate has been seled in by the funeral director, page 2 should 1 | H | 27. Manner of Death 1 V Natural 5 Pend | 28a. Date of Injury (Month, Day,Yea ding stigation | 28b. Time o | · · · · · · · · · · · · · · · · · · · | ry at Work? 'es 2 No | 28d. Describe I | now injury occurre | d |
| Division spital or Attent hours after death neral Director: | Certification: | 3 Suicide 6 Coul 4 Homicide dete | d not be z8e. Place of Inju | ry - At home, farm, st | | | or Town, S | tate) | r or Rural Route Number, City |
| Divis To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b | Medical | one) 2 ✓ Medical Exa | hysician: To the best of my miner:On the basis of examinand manner stated. | knowledge, death occ nation and/or investig | curred at the time, da gation, in my opinion 29c. Licens | , death occurred | d due to the caus at the time, date | and place, and du | ue to the cause(s) |
| 010. | Σ | 29b. Signature and title of certifie | • | | O.C.1 | | | February 28 | d (Month, Day, Year) 3, 2009 |
| 120 | | | sistant Medical Exami | ner 111 Penn | Street, Baltimo | ore, MD 2120 | 1 | | |
| S Regis | tate | PM 43 PF 1.1 | 6 2009 32. Redistrar's | D. A | backer | | | | |

Funeral Director

Baltimore, Maryland 21215-0036

physician a the burial-1 P.O. Box 68760. Division of Vital Records, Jas

1. Decedent's Name (First, Middle, Last) March 3, Year 2009 **Physician** 3:33P. Garni ta Jeanne Sutton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Village Prince George's Silver Spring If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Sept. 22, 1930 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days 1 □ M 2 🕶 F 78 468-30-8314 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Evandrat nust be notified at 1 ☐ Yes 2X No Maryland Montgomery Silver Spring Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Mudical Evalution in 181 be nonce. 20904 3118 Gracefield Road, #T15 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo If Yes, Give Year or Dates: White ģ Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Floyd Edward Perrizo Florence Josephine O'Neil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2705 Aloha Place Bowie, Maryland 20716 Lynne M. DeWitt -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 3/5/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Obstructive Sleep Apnea Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 XNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Coronary Artery Disease; Hypertension 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 🔼 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the form 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number dion MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Rol 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ^{Day} 2009 **Physician** Velma Marilyn Rubinstein Siegel 12:00A 28, Feb. /Medical 4b. City, Town, or Location of Death Gaithersburg 4c. County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) Examiner 20701 Woodfield Road 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months Days Hours 80 577-40-5831 Oct. 25. 1928 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a Modical Examiner must be notified at 1X Yes 2 □ No Gaithersburg Director Montgomery MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20882 20701 Woodfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 White 1 □Yes 21√2 No Specify Specify: ģ 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and 2 should be fi Health and Mental H Clara Oberfeld Louis Rubinstein ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau once. 20701 Woodfield RD., Gaithersburg, MD 20882 Stacie Siegel / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King David Mem. Gardens 3/02/09 Falls Church, VA 23a. Part J. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each fine.

Immediatr. Cause (Final disease or condition resulting in death)

a. Cardiovascullar 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chambers Funeral Home & Crematorium, 580 1737 level and Avenue, Riverdale, MD 20737 Physician /Medical Examiner Years Small Vessel Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence offs. Examine Physician; The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as attending properties for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant et time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day 5 Other (specify) Division of Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. þ Alzheimer's Dementia 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' this certificate 1 ∐Yes 2 X No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? e Hospital or Attending P 24 hours after death.
e Funeral Director; After t letely filled in by the funera 5 Pending investigation 1 X Natural 1 Tyes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical npletely (Check only and manner stated. the 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of parton who completed cause of

GEORGIA AVE

d cause of death (her) 23a) (Type, Print) Merlyn & Vemury,

ALE SIL VEK PRING

31. Registrar's Signature

D3579/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 ear March 10:01A. M **Physician** 3, Mauri Lynn Sampson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 7901 Laurel Lakes Court, #102 Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 6, 1949 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 59 Months Days Hours Min. Washington 1 □ M 2 💢 F 577-68-3084 **Director** Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be multhed at Prince George's Laurel 1 Yes 2 No Mərylənd Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 20707 7901 Laurel Lakes Court, #102 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 🕍 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary_(0-12) College (1-4or 5+) Administrative Assistant Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley M. Dunlap Andy Thomas Green ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 5212 Cochran Road Beltsville, Maryland 20705 Kelly Hornig -daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Crematory 3/4/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald VoresBorgwardt Funeral Home, PA Wonald 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 years Immediate Cause (Final Chronic Obstructive Pulmonary Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to min solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? 1 □ Yes 2 【XNo certificate 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☐XNo this 27. Manner of Death 14 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident within 24 hours after death to the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2

Registra

State

row

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Armstrong, M.D. 14201 Laurel Park Drive, #102 Laurel, Maryland 20707

D43237

March 4, 2009

| | | • | For State Registrar | State of Ma | aryland / [| • | rtment o <i>tificate</i> | | | d Men | | | 2009 | 09114 | |
|----------------------------|--|-------------------|---|---|--|-----------------------|---|--|-------------------------------|--------------------------|---|----------------------|--|--|--|
| | | | Decedent's Name (First, Middle, Las | t) | | | | | | | 2. Date of Death | | | 3. Time of Death | |
| | Physicia /Medic | | Claude R. Sloan, | Sr. | | | | | | F | ebrua | ry 28 | B, 2009 | 1:40 p M | |
| | Examin | | 4a. Facility Name (If not institution, give | | | | 4b. City, Tov | | | eath | 4c. County of Death Anne Arur | | nindo] | | |
| par . | | | 342 Sherman Aven 5. Social Security Number 6. Se | | e (In yrs. last bii | rthday) | If Under 1 | | nold Under 24 F | Hrs. 8 I | Date of Birth | 1 | | | |
| Н | Funeral Director | | | M 2□F | | Yrs. | | | | 1in. (| Month, Day | , Year) | 932 West | olace (State or Foreign otry) Virginia | |
| | pr , | | Usual Residence of Decedent | | 10c. City, Tow | | notion | | | | | | 11 | 0d. Inside City Limits | |
| | shov | è | 10a. State 10b. County | | | | Jation | | | | | | | 1 □ Yes 2√2 No | |
| | the N 28a-1 | Director | MD Anne Ar 10e. Street and Number | under | Arno | <u> </u> | 10f. Zip Co | ode | | | 1 | 10g. Citiz | en of What Cour | ntry? | |
| | 3a or | al Di | 342 Sherman Aven | ue | | | | 21 | 012 | | | | USA | | |
| | ems 2 | Funeral | 11. Marital Status | Armed Forces? | Was Decedent Ever in U.S. 13. W Armed Forces? | | | Was Decedent of Hispanic Origin? (Specify Y f Yes, specify Cuban, Mexican, Puerto Rican | | | y Yes or No- an, etc.) 14. Race - Am | | 4. Race - Americ Black, White, | | |
| 36 | filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ant, the Medical Exercitiver must be notified at | γFι | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 MYes 2 ☐ i | | | l□Yes 2 | | Specify: | | | - 1 | Specify: Whi | te | |
| 21215-0036 | hour atural | Completed by | 15. Decedent's Ed | | | | Decedent's Usual Occupation (Give kind of work done during most of working) | | | | 16b. Kind of Busines | | d of Business/In | dustry | |
| 215 | hin 72 e. an "na | plet | (Specify only highest grade Elementary/Secondary (0-12) | de completed) College (1-4or 5 | 5+) | (Give life. [| kind of work o OO NOT use i | done duri retired) | ing most of | working | | | | | |
| 7 | ed wit ygien er th | Son | 12 | | U | nite | d Stat | | | | -4 883-1-11- | 8.6-1al (| Milita | ıry | |
| Maryland | ntai H ed oth | Be | 17. Father's Name (First, Middle, Last) David Sloan | | | | | 18 | 3. Mother's I Wilma | | erta i | | , | | |
| Ž | should nd Me mark matic | မ | 19a. Informant's Name/Relationship (7 | vpe. Print) | 198 | o. Mailin | ng Address (Street and Number or Rural Route Number, City or Town, State, Zip C | | | | | Code) | | | |
| Z | is 1 and 2 soft Health are item 27 is | | Claude Ray Sloan. | Jr./Son | 9 | 9814 | James | stowr | n Stre | et | Watts] | burg | , PA 164 | 42 | |
| ore, | es 1 a of He f item r othe | | 20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐ | • | 20b. Place o | f Dispo | sition (Name natory or othe | of er place) | Ma | Date arch | 4 | 20c. Loc | cation - City or To | wn, State | |
| <u><u>E</u></u> | ment tant: I | | 4 ☐ Donation 5 ☐ Other (Specify |) | Atlan | - | Cremat | | - : 2 | 2009 | · / (| Glen | Burnie, | MD | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exercitive must be nutified at once. | y) | 21. Sign ture of Fym VI Service Licen | OU | | Ba 49 | Name and A rranco 5 Gov. | Address 6 8 5 Rit | of Facility Sons, cchie | P.A. Hwy. | Seve Seve | erna erna | Park Fu Park, M | neral Home 1D 21146 | |
| Е | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only | olications that caused one cause on each li | the death. Do | | | | | diac or re | spiratory an | rest, | | Approximate Interval Between Onset and Death | |
| - | Physician | | Immediate Cause (Final disease or condition resulting in death) | a | | .UV | rg Co | IVICI | er | | | | | 21/21/11 | |
| | /Medical Examiner | | Toolaing in docum | Due to (or as | a consequence | of): | | | | | | | | | |
| | | je. | Sequentially list conditions, if any, leading to immediate | b. Due to (or as | a consequence | of): | | | | | | | | | |
| | ocuted nd transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | c | | | | | | | | | | | |
| 90, | cate be executed physician and the burial-transit | al Exe | resulting in death) Last | Due to (or as | a consequence | of): | | | | | | | | | |
| 8760, | | dical | | .d | | | | | | | | - 1 | | | |
| Box 6 | n certifi anding use at | n/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | ۰ | 7e | | | | | 2 | 3d. Date of deliv | ery | |
| Ö. | The law requires that the death certifiate has been signed by the attending ate has been signed by the attending bage 2 should be detached for use as | Physician/Me | in the past 12 months? 1 □ Yes 2 □ No | | 2 □ Fetal deatl at time of death | | ☐Ectopic pred ☐Other (spec | | | | | | Month | Day Year | |
| P.O. | d by the | Phy | 9 ☐ Unknown Part II. Other significant conditions c | | ut not reculting i | in the w | ndorlying cau | sa diyan | in Part 1 | | 23e Did to | nhacco us | se contribute to t | he cause of death? | |
| | signe d be d | þ | rait ii. Other significant conditions c | ontributing to death L | di not resulting i | in the u | nderlying cau | se giveir | iii raiti. | | | es 2 | | pably 4 ☐ Unknown | |
| COL | v requ been shoul | letec | | | | | | | | _ | 24a. Was a | an | 24b. Were auto | ppsy findings available | |
| Ä | he law te has age 2 a | Completed | | | | | | | | _ | autop _ perfor | sy | | mpletion of cause of | |
| ital | | Be C | 25. Was case referred to medical | | | | | 2 | 6. Place of | Death (C | 1∐Yes heck only o | -() | ILlifes | 2 110 | |
| | Physical this ce al direc | | examiner? 1 ☐ Yes 2 SNo | Hospital: 1 ☐ Inpati | ent 2 ER/O | utpatier | | Other: | 4 🗀 Nursir | ng Home | 5 Resid | dence 6 | □Other (Speci | fy) | |
| n o | ding Physician: The In. After this certificate hortheral director, page | iuo | 27. Manner of Death 1 Matural 5 ☐ Pending | 28a. Date of Inju (Month, Da | | Time of Injury | f 280 | . Injury a Work? | | 28d. | Describe h | now injury | occurred | | |
| isio | Attending Physician: If death. ector: After this certific by the funeral director. | icat | 2 Accident investigation 3 Suicide 6 Could not be | | jury - At home, fa | arm, str | | | s 2□No | 28f. | Location (S | Street and | reet and Number or Rural Route Number, | | |
| Division of Vital Records, | after after Direct | Certification: To | 4 Homicide determined | building, e | c. (Specify) | , | , | | | | City or Tow | | | , , , , , , | |
| | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar | ysician: To the best niner: On the basis of and manner st | of examination a | je, deat ind/or in | h occurred at vestigation, in | the time n my opir | , date and p nion, death o | olace, and occurred a | due to the at the time, | cause(s) date and | and manner as a place, and due to | stated. o the cause(s) | |
| | To the I within 2 To the I complet | Me | 29b. Signature and title of certifier | | | | 29c. l | icense n | number | | | | e signed (Month, | | |
| | V. | 5 | > 4 Lever | uilsu | 9 | | _ 1 |) 10 | 1839 | 8 | | 3 | 13/20 | 09 | |
| | NO | | 30. Name an laddre's of person who | completed cause of | death (Item 23a) | (Туре, | Print) | Bes | tgate | e Ro | 1. A | ИИ | 13/20 apols, | und. | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Regist | rar's Signature | 1 | | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 28, 2009 Janet Y. Shelley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 9. Birthplace (State or Foreign Country) 1942 West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year. Months Days 1 □ M 2 🗓 F 66 233-66-9724 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "nation Express" and to a natified at 1 XYes 2 No Director Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 609 Crawfords Ridge Road 21113 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 Ϊ No Specify Specify: \$ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na International Elementary/Secondary (0-12) Administrative Assistant Monetary Fund 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Velva Johnson Roland Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traunonce. Robert E. Shelley II/ Husband 609 Crawfords Ridge Road Odenton, MD 21113 20b. Place of Disposition (Name of cemetery crematory or other place)
Davis
Memorial Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/2009 Cumberland, MD Memorial 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Just Winz Physician disease or condition resulting in death) > /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 □Yes 2 ■No Day 5 Other (specify) ed by the a 9 \ Unknown 9 Unknown cate has been signed page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 3 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 PNo 1 Inpatient 2☐ER/Outpatient 3☐ DOA Medical Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide T-critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Division of Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled Hospital

Baltimore, Maryland 21215-0036

29b. Signature and title of cartifier

037136

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and Drow Checker, Mo 0,00 00 31. Date filed (Month Day)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Lorraine Rentha Sciese March 4:13 AM 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2√2 F 217-28-1425 March 09,1932 PA Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be modified at 1 ☐Yes 2√ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 13419 Round Top Road 21750 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black. White, etc within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. **7 is marked other than "**r Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Manufacture 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Leroy W. Starliper Rentha Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun 14535 Tollgate Ridge RD Hancock, MD 21750 Junior W. Starliper/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/12/2009 Big Cove Tannery, PA 4 ☐ Donation 5 ☐ Other (Specify) Antioch Cemetery 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Decins Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASLATIC COLORECTAL CHICK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e IRUS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed Examir HYPERTETIO burial-transi and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial MELLITUS DIABC Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cate has been signated page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate h 1 □Yes 2 □No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MCHAMMER AZIZ D66892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Antietan St. Hagerstown, My 21740 Date filed (Month, Day, Year) State Registrar

DIL 8

| Director The purpose of the purpose | 3. Time of Death O410 Any lace (State or Foreign try) MD Od. Inside City Limits 1 |
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| Physician (Medical Examiner Medical Examiner Memorial Hospital Gounds) Funeral Director Funeral Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Days Hours Min. Days Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Days Hours Min. Days Days Days Hours Min. Days Hours Min. Days Days Hours Min. Days Hours Min. Da | Any lace (State or Foreign try) MD od. Inside City Limits 1 \(\text{Yes} 2 \square \text{No} \) |
| Examiner 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegary Cumberland 5. Social Security Number 214-34-1205 10 Months | any lace (State or Foreign try) MD Od. Inside City Limits 1 □ Yes 2 □ No |
| Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth 90 Birth | od. Inside City Limits 1 □Xes 2 □ No |
| Director 214-34-1205 1 M 2 F Feb 6, 1937 | od. Inside City Limits 1 □Xes 2 □ No |
| State Hostogenee of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. City 1 | 0d. Inside City Limits 1 ☐Xes 2 ☐ No |
| 2 of Part Administration 2011 14301 Direction Minder Chimpenation Minder | 1 ⊈Yes 2 ☐ No |
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| 2 of Part Administration 2011 14301 Direction Minder Chimpenation Minder | |
| 20a. Method of Disposition Comparison C | ^{Code)} 1D 21502 |
| Scarpelli Funeral Home, P.A. 3/18/2009 Cresaptow | wn, State |
| 🛨 🛱 ா க் 🗜 வர் 📗 21. Signettus of Funeral Service Licensee // 22. Name and Address of Facility | vn MD |
| 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | Approximate Interval Between |
| Physician Immediate Cause (Final disease or condition | Onset and Death |
| /Medical resulting in death) Due to (or as a consequence of): Examiner | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of): | |
| The state of the s | |
| Cause Disease or Injury that initiated events resulting in death) Last Cause Disease or Injury that initiated events resulting in death) Last Co. Due to (or as a consequence of): Due to (or as a consequence | |
| tificate be gas the burning as the b | |
| The part of the pa | - |
| In the past 12 months? In the | Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the | e cause of death? |
| To be a significant conditions continuous to the bound of the significant conditions continuous to the bound of the significant conditions continuous to the bound of the significant conditions continuous to the bound of the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions continuous to the significant conditions conditio | ably 4 Unknown |
| 24a. Was an autopsy prior to comp | psy findings available apletion of cause of |
| E death? | 2 .0 0 |
| 24a. Was an autopsy performed? Injury of large auto | <i>(</i>) |
| O a figure 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work? | , |
| O G G G G G G G G G G G G G G G G G G G | l Route Number |
| 1 Yes 22No 1 Montation 2 ER/Outpatient 3 DOA Other (Specify) 28d. Describe how injury occurred 28d. Describe how inj | |
| 29a. Certifier Check only 29m Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause of t | , route riginger, |
| and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date signed) | tated. |
| 20 News and address of passes who completed on use of death (New 220) (Time Paint) | tated. the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130 Penn Fyl vania 14V M Emmanuel 050 - Boamah Cumber land MD 21502 | tated. the cause(s) |
| State Registrar NAR 2 0 2009 32. Registrar's Signature | tated. the cause(s) Day, Year) |

DHMH 17 Rev 1/2001

ORIGINAL

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Februar 25 200g /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (enter hester hive Hospital If Under 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day) 5. Social Security Number **Funeral** Min. 1 XM 2□ F Months Days Hours 5/19/1936 Director 213-32-8932 72 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinatmanst be a without 1 □Yes 2X No Director KENT ROCK HALL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21573 PINE LANE 21661 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 XYes 2 No 1957— If Yes, Give Year or Dates: 1963 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 11 MASON CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ANDREW TOULSON EVELYN KATHRYN CHAIRES ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health at 21573 PINE LANE ROCK HALL, MD 21661 NANCY S. TOULSON/WIFE other t permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2009 WESLEY CHAPEL ROCK_HALL, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sex hamie Immediate Cause (Final mint elis roteus Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rostatz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence off Examine certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by Colon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No this certificate 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12 State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

FER 27 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

luste

Christma lurne



29c. License number

066371

Street Cheshrtown

29d. Date signed (Month, Day, Year)

25,2009

Man land 21620

| | 1 | For State Registrar | | State o | f Maryla | | rtificate of l | | | Re | eg. No. U U | 19 | 09119 | |
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| Physicia | | | ne (First, Middle, Las harles Turne | | | | | | | e of Death h th 5,: | | Year | 3. Time of Death 5:00a M | |
| /Medic Examin | | 4a. Facility Name | (If not institution, give | | mber) | | 4b. City, Town, or | | f Death | | 4c. County of | | | |
| Funcial | | | | | | (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi | | | 24 Hrs. 8. Dat Min. (Mo | e of Birth | | 9. Birtho | elace (State or Foreign | |
| Funeral Director | | 294-12-95 | 515 | ∑ M 2□ F | | 86 Yrs. | Months Days Hours Min. | | Octo | in. 8. Date of Birth (Month, Day, Yea October 12, | | (Par) Country) OH | | |
| yland now | | Usual Residence | 10b. County | | 10c. | City, Town or Lo | | | | | | 1 | 0d. Inside City Limits 1 ☐ Yes 2 No | |
| e Mar 8a-f st | ector | MD | Montgome | ry | | Silve | r Spring | | | 1 | 0g. Citizen of W | hat Cour | | |
| with the | al Dir | 10e. Street and No. | slie Street | | | | 20902 | | | | USA | | | |
| IN ELL 13-UU30 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Modreal Evanding rate to notified at | by Funeral Director | | rried 2 XM Married | 12. Was Dec Armed Fo 1 XX es If Yes, G Year or D | orces? 2 🔲 No | | Was Decedent of H If Yes, specify Cubin 1 ☐ Yes ②XXNo | Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ricar ☐ Yes ②▼No Specify: | | án, etc.) Bla | | ace - American Indian, ack, White, etc. ify: White | | |
| L 13-0030 thin 72 hours aft e. an "natural", or Medical Exon | | | 15. Decedent's Ed | | | 16a Dane | eedent's Usual Occupation re kind of work done during most of working DO NOT use retired) | | of working | | 16b. Kind of Business/Industry | | dustry | |
| within 7 ene. | Completed | Elementary/Sec | | 0-11 (4.45-) | | tric Motor Technician | | | | | Electrical Service | | | |
| Vian Vuld be Mental arked atic ev | To Be Co | 17. Father's Nam | e (First, Middle, Last urner |) | | 18. Mother's Nar Hazel I 19b. Mailing Address (Street and Number or Re | | | er's Name (First, zel Doll | , Middle, I | Maiden Surnam | e) | | |
| Taryla 2 should I 3 and Men 1s marke raumatic | F | | Name/Relationship | | | I . | | | | | | State, Zij | o Code) | |
| altimore, N rmit. Pages 1 and 3 partment of Health portant: If item 27 y injury or other tr | | 20a. Method of D | 2 ☐ Cremation 3 ☐ | Removal from | State N | b. Place of Disp | Leslie Str osition (Name of ematory or other pla emorial Par | ce) | Date March 9, | | 20c. Location - Falls Chr | , | | |
| Baltimo permit. Page Department of Important: If any Injury or | | | n 5 ☐ Other (Speci Funeral Service Lice | | | F | 22. Name and Addr Tancis J. 0 00 Universi | ess of Facility | Funeral: | Home : Silve: | Inc. r Spring, | MD 2 | 0901 | |
| Physician | | 23a. Part 1. Ente shock, or h Immediate Caus disease or cond resulting in deat | ition | one cause on a. Met | astatic | death. Do not e | | ng, such as | cardiac or resp | iratory an | rest, | | Approximate Interval Between Onset and Death Months | |
| Box 68760, ———————————————————————————————————— | edical Examiner | Sequentially list if any, leading to cause. Enter Ur Cause (Disease that initiated eve resulting in deat | conditions, immediate derlying | b. Tel | minal I | Pneumonia nsequence of): nsequence of): | uence of): | | | | | Days | | |
| I Records, P.O. Box 68 The law requires that the death certifica are has been signed by the attending ph page 2 should be detached for use as it | Physician/Med | IF FEMALE: 23b. Was deced in the past 1 Yes 9 Unkno | 12 months? 2 No | outcome of presented by the birth 2 and at time known | B ☐ Ectopic pregnar | | | 23d. Date of delivery Month Day Year | | | | | | |
| cords, P.O. w requires that the de been signed by the should be detached | ρ | | gnificant conditions rca, Proteir | | | t resulting in the | underlying cause g | iven in Part I | 1. 2 | 23e. Did tobacco use contribute to the cause of the caus | | | | |
| Recor | Completed | | | | | | | | | 24a. Was autop perfo | osy ormed? | Were au prior to d death? 1 ∐Yes | topsy findings available completion of cause of 2 1240 | |
| Vital Fictorial Fictorial The Certificate ector, pag | BeC | 25. Was case re examiner? | eferred to medical | Hamitali | | | | la a r | e of Death (Che | | | | | |
| n of ng Phys | ation: To | 1 ☐ Yes 2 27. Manner of D 1 ☐ Natural 2 ☐ Acciden | eath 5 Pending | 28a. Da (M | npatient te of Injury onth, Day, Ye | 2 ER/Outpat 28b. Time Injury | of 28c. Inj | 4 🗆 14 | 28d. [| Describe I | dence 6 Ott | red | | |
| Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Suicide 4 Homicid | de determine | ed bu | | | street, factory, office | | | City or Tol | wn, State) | | ral Route Number, | |
| Hospital 24 hours 8 Funeral 1 etely filled | Medical | | 1 E ertifying 2 Medical Ex | aminer: On the | the best of me basis of exa anner stated | amination and/or | eath occurred at the investigation, in m | time, date a opinion, de | and place, and death occurred at | the time, | , date and place | , and due | to the cause(s) | |
| | Me | N 0 | and title of certifier | ypanic | ch RSI | m arc | | nse number 0654 | | | 29d. Date signed 3/2 | 1 | h, Day, Year) | |
| potl | | 30. Name and a | address of person what Ann Supani | ch 1 | ause of death | n (Item 23a) (Typest Glen F | Road, Silve | r Sprin | g, MD 209 | 10 | | | | |
| S Regis | tate strar | | Month, Day, Year) | 009 | . Registrar's | Signature 6. | ales | | | | | | | |

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| | Funeral Director | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-1 ehow eny injury or other traumatic event, the Medital Examiner must be intillised at once. | |

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

| | 1 | State Registrar | | | Cei | tificate of L | Death | | Reg. No | 0. | | | |
|-------------------------------------|---|--|--|---|---|---|---|--|---|---|--|--|--|
| ian | | 1. Decedent's Name <i>(First, Middl</i> e, La Hailey Mari | | ten | | | | 2. Date of De Month Februa | | | 3. Time of Death | | |
| cal ner | 4 | 4a. Facility Name (If not institution, give | | er) | | | Location of Death | 1 | | c. County of Dea | | | |
| | | Holy Cross Hospi | | | | | Silver Spring If Under 1 Year If Under 24 Hrs. | | | Montgome | | | |
| | | 5. Social Security Number 6. S None Usual Residence of Decedent | 1 M 2 F 7. | Age (In yrs. ia | Yrs. | Months Pays | Hours Min. | 8. Date of Bir (Month, Di FEB 16 | ay, Year | 009 Mar | pholace (State or Fore puntry) Yland | | |
| _ | 1 | 10a. State 10b. County | | | Town or Lo | | | | 10d. Inside City | | | | |
| Director | - | Maryland Monts | gomery | Si | Lver S | pring 10f. Zip Code | | | 10a Ci | itizen of What Co | Λ | | |
| 2 | | 3809 Palmira I | ane | | | 2090 |)6 | | United States of | | | | |
| To Be Completed by Funeral Director | | 11. Marital Status 1 ☑ Never Married 2 ☐ Married | 12. Was Decede | 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No | | | Vas Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, e | | | 14. Race - American Indian, Black, White, etc. | | | |
| ted by | | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E | Year or Date | s: | 1 ☐ Yes 2 1 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of workin | | | | | Specify: Caucasian | | | |
| Completed | - | (Specify only highest gr Elementary/Secondary (0-12) | ade completed) Coltege (1-4 | or 5+) | (Give life. | kind of work done of DO NOT use retired None | during most of world) | king | None | | | | |
| ပိ | | 17. Father's Name (First, Middle, Last |) | | | Hone | 18. Mother's Nam | ne (First, Middle | None Middle, Maiden Surname) | | | | |
| To Be | | Unknov | m | | | | Betty | Mariso1 | | | | | |
| - | Unknown Betty Marisol Totten 19a. Informant's Name/Relationship (Type, Print) Betty Marisol Totten - Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3809 Palmira Lane; Silver Spring, MD 20906 | | | | | | | | | | | | |
| | 2 | 20a. Method of Disposition 1 | | | | | | | | | | | |
| | | 4 Donation 5 Other (Special Service Lice | | rt. | 22 | . Name and Addres | ss of Facility Sin | nple Tri | Lbut | e Funera | 1 & Crema | | |
| 1 | 1 | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | | | | 40 Rockv | | | | e, MD 20 | Approximate | | |
| at Examiner | | | | | | | | | | | | | |
| edical | IE EEMALE: | | | | | | | | | | | | |
| Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Live birth 2 □ Fetal death in the past 12 menths? 4 □ Pregnant at time of death in the past 12 menths? | | | | | | | | 23d. Date of delivery Month Day | | | | |
| D S | p at the states significant contained to death but not resulting in the underlying cause given in Fact. | | | | | | | | | othe cause of death robably 4 Unknown | | | |
| a te | - | | | | | -12 | | | opsy ormed? | prior to death? | utopsy findings avail- completion of cause | | |
| ompleted | 11.163 24110 | | | | | | | | | | | | |
| e C | examiner? Hospital: Other | | | | | | | | | | | | |
| o Be C | | 1 ☐ Yes 2 ☑ No | Hospital: 1 2 Inp | atient 2 E | R/Outpatier | it 3 DOA | 4 Nursing n | e of 28c. Injury at 28d. Describe how injury occur | | | | | |
| To Be C | | 1 Yes 2 √No 27. Manner of Death 1 √Natural 5 Pending 2 Accident investigation | 28a. Date of (Month, | | R/Outpatier 28b. Time o Injury | 28c. Injun | v at k? | | | ury occurred | cify) | | |
| ertification: To Be C | | 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of (Month, | Injury Day Year) | 28b. Time o Injury | 28c. Injun | v at k? | 28d. Describe | how inju | and Number or R | ural Route Number, | | |
| Certification: To Be C | | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not to determined 29a. Certifier 1 Certifying P | 28a. Date of (Month, | Injury Day Year) Injury - At hor, etc. (Specify) est of my knows of examinati | 28b. Time o Injury | 28c. Injun Wor M 1 | y at k? Yes 2 □ No | 28f. Location City or To | (Street a | and Number or Rite) | ural Route Number, s stated. | | |
| ertification: To Be C | | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not t determined 29a. Certifier (Check only) 2 Medical Exa | 28a. Date of (Month, on 28e. Place of building hysician: To the bominer: On the basi | Injury Day Year) Injury - At hor, etc. (Specify) est of my knows of examinati | 28b. Time o Injury | 28c. Injun Wor M 1 | y at k? Yes 2 □ No ne, date and place pinion, death occu | 28f. Location City or To | (Street a bwn, State cause); date an | and Number or Rite) | ural Route Number, s stated. e to the cause(s) | | |
| Certification: To Be C | | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not 1 determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Example 1 | 28a. Date of (Month, on 28e. Place of building hysician: To the bominer: On the basi | Injury Day Year) Injury - At hor, etc. (Specify) est of my knows of examinati | 28b. Time o Injury | 28c. Injun Wor M 28c. Injun Wor I eet, factory, office h occurred at the tim vestigation, in my o | y at k? Yes 2 □ No ne, date and place pinion, death occu | 28f. Location City or To | (Street a bwn, State cause); date an | und Number or R fe) s) and manner a nd place, and du | ural Route Number, s stated. e to the cause(s) | | |
| Certification: To Be C | | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not 1 determined 29a. Certifier (Check only one) 1 Certifying P 2 Medical Example 1 | 28a. Date of (Month, on 28a. Place of building hysician: To the base and manner of completed cause | Injury Day Year) Injury - At hor, etc. (Specify) est of my know s of examinating stated. | 28b. Time of Injury me, farm, strictly deadge, deat on and/or in 23a) (Type. | 28c. Injun Work M 1 = 28c. Injun Work 1 = 29c. Injun 29c. Licens D 5 0 | y at k? Yes 2 No ne, date and place pinion, death occu | 28f. Location City or To | (Street above, State) cause(s, date are 29d. Date) | und Number or R fe) s) and manner a nd place, and du | ural Route Number, s stated. e to the cause(s) | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 & 29d per phys. 6890 4/3/09 dk
State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registrar Certificate of Death Rea No 2. Date of DeathMar 1. Decedent's Name (First, Middle, Last) 2009 3. Time of Death 1 Month Stylianos Tzimoyannis 1:52 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Agnes altimore tospita If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country)
____ 8. Date of Birth (Month, Day, Year) June 28, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Days Hours Months 1 X M 2 □ F 75 577-78-9278 Egypt Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1502 Frederick Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banquet Waiter Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Panaviotis Tzimovannis Ekaterina Vouvakis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caterina P. Borg/Daughter 44 Fox Run Way Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition March 4 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Barranco & Sons 21. Signature of Fulleral Service Line P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death acute disease or condition resulting in death) Due to (or as a consequence of) -oronasy Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{M} \) No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

/Medical Examiner The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician;

7

Physician

Examiner

Funeral

Director

28a-f show

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Items 23a

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician

certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran

director,

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After this

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neral Director: A
filled in by the fu death.

Director

Funeral

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Completed

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Physician/Medical Examiner

Completed by

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other traumatic event, the Medical Examinar must be notified at

the Maryland

and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Medical Certification: To within 24 hours a

State

29c. License number

29d. Date signed (MoMaday, Yea 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 10, a190 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MAR 05 2009

29b. Signature and title of certifier

Registrar

MARK AllAN Tippett 09-01213

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 09122

| | 1- For State Certificate of D | | Reg. No. |
|---|---|--|---|
| Physician/ edical Examiner | 1. Decedent's Name (First, Middle,Last) Mark Alan Tippett | 2. Date of De Month February | eath Day Year 0000 hrs |
| dicar Examiner | 4a. Facility Name (if not institution, give street and number) 4b. | City, Town, or Location of Death Lexington Park | 4c. County of Death St. Mary's |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24Hrs. 8: Date of | Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign District of |
| Director | 218-80-0181 1X M 2 F 46 Yrs. | March | n 21,1962 Country)Columbia |
| faryland 28a-f show any Lat once. | 10a. State 10b. County 10c. City, Town or Location Maryland St. Mary's | Lexington Park | 10d. Inside City Limits 1 Yes 2 No |
| h the Maryland 3a or 28a-f sho totified at once. | 21570 Columbia Street | 0f. Zip Code 20653 | 10g. Citizen of What Country? USA |
| er death witens 2 r must be r | 1 Never Married 2 X Married Armed Forces? If Yes | Decedent of Hispanic Origin? (Specify Yes or specify Cuban, Mexican, Puerto Rican, etc.) es 2 X No specify: | No- 14. Race - American Indian, Black, White, etc. Specify: White |
| 5 72 hours afti an "natural" cal Examine | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Main | Usual Occupation (Give kind of work done of working life. DO NOT use retired) tenance Manager | 16b. Kind of Business/Industry Apartment Complex |
| 21215-0036 July be filed within 72 hours Mental Hygiène. marked other than "natuu cerent, the Medical Exam To Be Completed I | 11 17. Father's Name (First, Middle, Last) Francis X. Tippett | 18.Mother's Name (First, Middl | |
| MD 21215 d 2 should be fil- lith and Mental H in 27 is marked aumatic event, t | 19a. Informant's Name/Relationship (Type, Print) Christopher Mark Tippett/Brother 29631 | ddress (Street and Number or Rural Route N Esser Court Mechanic | Number, City or Town, State, Zip Code) |
| | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metropolitan | on (Name of cemetery, place) Date March 17, | 20c. Location - City or Town, State Alexandria, Virginia |
| Baltimore, permit. Pages I a Department of He Important: If ite | Machanet P. | ne and Address of Facility ttingley-Gardiner Funeral O. Box 270 Leonardtown, 1 | Home , P.A. D 20650 arrest, shock, or heart Approximate Interva |
| Physician M dical xaminer | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate a. No identifiable anatom Due to (or as a consequence of): b. Due to (or as a consequence of): | | Detween Onset and |
| ecuted and transit | | erME, g889 3/24/09 TT | |
| Division of Vital Records, P.O. Box 68760, note Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Exidence of the property of the | | death 3 Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the director. To Be Completed by Physician/ | | 1 | old tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Vas an 24b. Were autopsy findings available |
| Division of Vital Records, P.O. and or Attending Physician: The law requires that the law Tree care. The record of the conficuence of the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director. Be Completed by Fertification: To Be Completed by Fertification: | | a p | utopsy prior to completion of cause of death? les 2 No 1 Yes 2 No |
| /ital sician: sician: is certif lirector, Be (| 25. Was case referred to medical examiner? Hospital: 4 Inpution 2 EP/Outnatient | 26.Place of Death (Check only one) 3 DOA Other Nursing Home 5 | Residence 6 V Other: Scene |
| n of Vinding Physich. The After this e funeral difficient To | | 1 ves 2 X No link | ibe how injury occurred |
| Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification: | 2 Accident Investigation 3 Sulcide 6 X Could not be determined Homicide 1 | , factory, office building, etc. 28f. Locati or Tov Lexin | on (Street and Number or Rural Route Number, Cit vn, State) 21609 Willis Wharf gton Park, MD |
| To the Hospital within 24 hours To the Funeral completely fille | | ed at the time, date and place, and due to the on, in my opinion, death occurred at the time, o | cause(s) and manner as stated. date and place, and due to the cause(s) |
| T W. T. S. | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | 29d. Date signed (Month, Day, Year) February 12, 2009 |
| | 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 | Penn Street, Baltimore, MD 21201 | |
| State Registra | 1 | 1 | |
| DHMH 17 Rev 1/2001 | OPIGINAL | | |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 FRANK GOLDSBORO VOSS /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner SALISBURY NICOMICC AKE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea 7/7/1937 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Delaware Director 222-22-8181 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examinar mast be multified at 1 XYes 2 ☐ No Director Pocomoke City MD Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21851 615 Market Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 No. 18 If Yes, Give 1958 Year or Dates 1963 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Management Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Alva Gerardi Walter Lee Voss, Jr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a important: if item 27 is any injury or other trainonce. 615 Market Street, Pocomoke City, MD 21851 Carole P. Voss (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Pitts Creek 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pocomoke City, MD 3/9/2009 Presbyterian Cenetery 21. Signature of Funeral Service Licensee Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatie **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sus to for self-consequence off Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 2 No 3 Probably 4 Unknown es Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 🟲 Certification: To this Date of Injury (Month, Day, Year) 27. Manper of Teath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner state within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

3A5+1

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Gua

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $?\; []\; []\; 9$ 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Venables OSHM /Medical 4c. Counfy of Death Facility Name (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, Year) 02/24/1960 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1**X** M 2 □ F 49 216-70-6546 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f shov coust by notified at 1 ☐ Yes 2 X No Director Wicomico Mardela Springs Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9003 Athol Road 21837 USA Funeral d other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 X No 1 ☐ Yes 2 🕱 No Specify: <u>}</u> white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) probation officer State of Maryland 12 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Thompson Marion W. Venables ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>0</u> Catherine Venables/wife 9003 Athol Rd., Mardela Springs, MD 21837 timore, 20b. Place of Disposition (Name of Stematery, crematory or other place)
St. Andrews Episcopal 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/9/09 Princess Anne, MD Church Cemetery 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Foneral Service Licens 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consuctioner of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Î 1 Appatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 27. Manner of eath Pate of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** PRISCILLA SISSOM WRIGHT 11:50 A M MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner KENT 5956 LANGFORD BAY RD. CHESTERTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex **Funeral** 1 □ M 2 🕅 F 67 215-36-2123 Director 7/26/1941 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f showing Medical Experiment regard by notified at 1 ☐ Yes 2 X No Director KENT CHESTERTOWN MD with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 USA 5956 LANGFORD BAY RD. by Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER AUTOMOTIVE 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NAOMI BENNETT HERBERT J. FLETCHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5956 LANGFORD BAY RD. CHESTERTOWN, MD 21620 J. MICHAEL WRIGHT/HUSBAND Department of Health Important: If item 27 any Injury or other trong once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/2009 CHESTERTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESTER-CEMETERY 22. Name and Address of Facili 21. Signature of Fungral Service Lice FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME SURC 130 SPEÉR RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DIABETES MELLITUS burial-trar resulting in death) Last Due to (or as a consequence of) O. Box 68760. nding physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant atter for u in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 No 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation after death.

Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a

To the Funeral D

completely filled i TV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 6 21620 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, OSC-1 100 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician Vear 23:02 PM 2009 Russell /Medical 4a. Facility Name (If nqt institution, give street and number) Examiner Hospita Year | if Under 24 Hrs. (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 213-20-2588 1**X**M 2□ F Yrs 110 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21661 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ★Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aborer onstruc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number of Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) anet 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Chapel Agron 4 ☐ Donation 5 ☐ Other (Specify) Signature 298 Worten MD 21678 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to (or as a consequence of): 4 deup resulting in death) /Medical **Examiner** Sequentially list conditions, if any, each global cause. Enter Underlying Cause (Disease or injury or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an 24b. Were autopsy findings aveilable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ≯ ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union NAMITA MOSPITAL. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar 3/9/09, MS, Kent Co. Certificate of Death Amended#26. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month **Physician** March 2, Arthur Allen Whittier 1918 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chester River Hospital Center Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 5/11/1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F 229-44-1691 70 VA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Mydical Experiment Department at a once. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director CHESTERTOWN OUEEN ANNE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21620 102 ROSIN DR. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE ò 3 Widowed 4 Divorced VIETNAM Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ FOOTBALL COACH EDUCATION 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN LAMONT ARTHUR WHITTIER ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 ROSIN DR. CHESTERTOWN, MD 21620 PAULA TARBUTTON/WIFE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CHESAPEAKE CREMATION: 3/4/09 STEVENSVILLE, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home 21. Signature of Funeral Service Lic w 130 Speer Rd. Chestertown, MD 21620 23a. Part 1. Enter the disease, or con shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Was an actopsy performed? has e 2 s this certificate har 1 □Yes 2 No 25. Was e referred to medical examine Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To idense 6 Other (Specify) s after death.

I Director: After this
od in by the funeral d 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 10051786 20

State Registrar Bldy B, Chestertown

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hndrew tergison M.D.

31. Date filed (Month, Day, Yeak)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Mams garet 12:08AM March 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 1, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 □ M 2X □ F I**lli**nois 217-74-4400 54 Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XVo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 20905 410 Marshal Manor Drive USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 X Never Married 2 Married 1 ∏ Yes 2 TNo Specify. White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John S. Williams Ellen S. Schaal 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Williams/Father 410 Marshal Manor Drive, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March Woodside Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Ashton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final u to (or as a consequence of) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Tetal death 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 7 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Donknown 25. 27.

Physician /Medical Examiner law requires that the death certificate be executed

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Baltimore, Maryland 21215-0036

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Examine Physician/Medical þ Completed funeral director, Be မ To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director; After the completely filled in by the funera Certification:

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| | | | | 24a. Was an autopsy performed? | 24b. Were autopsy findings availal prior to completion of cause death? 1 ☐ Yes 2 ☐ No | |
| 25. Was case referred to medical | | | 26. Place of Dea | th (Check only one) | | |
| examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☑Inpatient 2 ☐ E | ER/Outpatient 3 🗆 D | OCA Other: 4 - Nursing H | lome 5 Residence 6 | i ☐ Other (Specify) | |
| 27. Manner of Death 1 | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury | occurred | |
| 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of injury - At hom building, etc. (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | sician: To the best of my knowl | | | | and manner as stated. | |

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Division of Vital Records, P.O. Box 68760,

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29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

32 Registrar's Signature

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

back

State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 39 AM CHARLES MACK WARD, SR. 0 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 40spice at Wicomico lisbu he If Under 1 Year | If Under 24 Hrs/ Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days Hours 1**X** M 2□ F Months Min. 215-26-4835 82 2/3/1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 115 Civic Avenue 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried 1 □Yes 2X No Specify Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Entrepenuer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Frances Shores Robert Lee Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Friar Tuck Lane, Salisbury, MD 21804 Harlan Ward (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Goodwill Methodist Cemetery 3/5/2009 Pocomoke, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral S Aice Licensee HOLLOWAY Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARBBROVASCULAR disease or condition resulting in death) ACCIDBNI

Physician /Medical Examiner

Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, once.

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0036

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| Collibrated by Fr | Part II. Other significant conditions o | ontributing to death but not res | sulting in the underlying | ng cause given in Part I. | 23e. Did tobacco 1 Yes 2 24a. Was an autopsy performed 1 Yes 2 No | 24b. Were autops: prior to comp death? | y findings available | | | | |
| ם מ | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Inpatient 2 | ER/Outpatient 3 | | eath (Check only one) Home 5 Residence | Other (Specify) | tospic z | | | | |
| ation: | 27. Manner of Death 12 Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how inju | | 1030.02 | | | | |
| Allina | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, street, fac | tory, office | 28f. Location (Street a. City or Town, State | nd Number or Rural F e) | oute Number, | | | | |
| ancai c | 29a. Certifier (Check only one) Certifying Ph Certifying Ph Certifying Ph Certifying Ph | nysician: To the best of my kniner: On the basis of examin and manner stated. | owledge, death occur ation and/or investiga | rred at the time, date and place tion, in my opinion, death occ | ce, and due to the cause(s curred at the time, date an | s) and manner as stat id place, and due to th | ed. le cause(s) | | | | |
| Ě | 29b. Signature and title of certifier | | | 29c. License number | 29d. Da | ate signed (Month, Da | y, Year) | | | | |

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Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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| | Discosioni . | | 1. Decedent's Name (First, Middle, Las | st) | | 2. Date of Dea | th | 3. Time of Death | | | |
| | Physici /Medi | | MARY ANNE WAR | D | | | | Month 03 | Day | Year 04/5 M | |
| 4 | Examir | ner | 4a. Facility Name (If not institution, giv | | er) | | or Location of Dea | | 4c. County | | |
| | | | TENINSULA REGIONAL | . 100. | Center | If Under 1 Year | AUS bU M | | - | VICOMIO | |
| | Funeral Director | | 231-42-8375 | m 2 2 3 F | Age (In yrs. last birthday) 71 Yrs. | Months Days | Hours Mir | | 937 | 9. Birthplace (State or Foreign Country) Virginia | |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits | |
| | Mary Ff sh | 햦 | MD Worceste | r | Stockton | | | | | 1 □Yes 2 XNo | |
| | or 28 | Funeral Director | 10e. Street and Number | | DEOCKEON | 10f. Zip Code | | 1 | 0g. Citizen of V | Vhat Country? | |
| | 23a ust b | īa [| 1206 Snow Hill Ro | ad | | 21864 | | | | USA | |
| | tems | nue | 11. Marital Status | 12. Was Deceder Armed Forces | s? | Was Decedent of I | Hispanic Origin? (an, Mexican, Pue | Specify Yes or No- erto Rican, etc.) | | e - American Indian, ck, White, etc. | |
| 215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Exercities must be notified at once. | b | 1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced | 1 ∐Yes 2∑ If Yes, Give Year or Dates | No | 1 □Yes 2 X No | | | Specify | | |
| 5-0 | 72 ho natur | Completed | 15. Decedent's Ec | ucation de completed) | 16a. Dece | dent's Usual Occup | pation | orkina I | 16b. Kind of Bu | usiness/Industry | |
| 121 | /ithin ine. han " | d E | Elementary/Secondary (0-12) | College (1-4o | r 5+) life. I | DO NOT use retire | d) | STRING | | | |
| d 21 | iled w Hygie ther t | | 17. Father's Name (First, Middle, Last) | 1 | Hairo | lresser | 18 Mothor's No | ame (First, Middle, I | Beaution Surnam | | |
| Maryland | should be filed withi and Mental Hygiene. marked other than umatic event, Inc. M | o Be | | | | | | , , , | vialueri Surriani | ie) | |
| ar. | shoul ind M imarl | 2 | Charles W. Hall 19a. Informant's Name/Relationship (| Type. Print) | 19b, Mailir | ng Address (Street | Mary Me | Rural Route Number | r. City or Town | State Zin Code) | |
| | alth a 27 is | | Beth Fillis (daug | nter) | | | | Pittsvill | | | |
| ore, | es 1 and 2: of Health a f item 27 is r other trau | | 20a. Method of Disposition | | 20b. Place of Dispo | sition (Name of | ce) | | | City or Town, State | |
| ij | Pages ment of I ant: If ite ury or of | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>) | | Goodwill Me | | i | 5/2009 | Pocomok | e, Maryland | |
| Baltimore, | permit. Departr Importa any Inju | | 21. Signature of Funeral Solice Licen | See A | 22 H | Name and Address Olloway | ess of Facility Funeral | Home, Pro Pocomoke | fessional | Association | |
| | ificate be executed Dyscien and Street transit Street burial-transit Street burial-trans | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only | lications that caus | ed the death. Do not ent | | | | | Approximate | |
| | | | Immediate Cause (Final disease or condition | | S 5/5 5/1 02 | GAN CAN 12 | 4 | | | Interval Between Onset and Death | |
| | | | resulting in death) | | as a consequence of): | end thice | - | | | 20A7S | |
| | | L | Sequentially list conditions, b. M. T.A. V. 5 PETACE MENT | | | | | | | | |
| | | ıjner | if any, leading to mineriate Due to (or as a consequence of). | | | | | | | | |
| 6 | | Examin | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 8760, | | dical E | | | | | | | | | |
| | | edic | | d | | | | | | | |
| Вох | eath certific attending p for use as | N/ | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | ī . | | | 23d. Dat | e of delivery | |
| . B | e deat ne att | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | | tat time of death 5 | Ectopic pregnand Other (specify) _ | ;y | | Mo | nth Day Year | |
| P.0 | that the denetation of the detached | Phys | 9 Unknown | | | | | | | | |
| JS, | Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as | | Part II. Other significant conditions of | | | | en in Part I. | T . | | ibute to the cause of death? | |
| or | w requires been sign should be | Completed by | Carl Ve Milliant | - TO CARTINO. | (1401) 1/2 | 03/2 | | 1 L Ye | s 2 No | 3 Probably 4 Unknown | |
| Rec | has l | ם | | | | | | 24a. Was ar autops | у р | Vere autopsy findings available rior to completion of cause of | |
| a | ician; The certificate hi ector, page | | 05.10 | | | | | perform 1 🗆 Yes 2 | | leath? □Yes 2□No | |
| ₹ | sician; certific lirector, | Be C | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 ☑ Inpa | tiont OFFNOrthation | t 3 🗆 DOA Oth | | ath (Check only one | | | |
| 0 | g Phys er this eral dii | <u>م</u> | 27. Manner of Death | 28a. Date of In | njury 28b. Time of | 28c. Injur | y at | Home 5 Reside | | | |
| ion | inding ath. r: Aft re fun | atio | 1 Natural 5 Pending 2 Accident investigation | (Month, E | Day, Year) Injury | M 1 🗆 | k? Yes 2 □ No | | | | |
| Division of Vital Records, | al or Atter after des Directo d in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of li building, e | njury - At home, farm, streetc. (Specify) | street, factory, office 28f. Location (Stre City or Town, | | | eet and Number or Rural Route Number, , State) | | |
| | To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. | Medical C | 29a. Certifier 1 Certifying Physical Certifier 2 Medical Example 1 | ysician: To the besiner: On the basis and manners | n occurred at the til vestigation, in my o | ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s) | | | | | |
| | To the virthin comp. | Me | 29b. Signature and title of dertifler | | | 29c. Licens | e number | 29 | 9d. Date signed | (Month, Day, Year) | |
| | | | 16 | | | D53 | 3551 | | 03/02 | 120-9 | |
| _ | 115 | | 30. Name and address of person who o | ompleted cause of | death (Item 23a) (Type, I | Print) | | / | · | | |
| R | A 15 | | JAMES C. Todd | nD 10 | DE CARRE | OCC St. | SAlis | bury 1. | Md 2. | 1801 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) NAR 0 5 2 | 32. Fégis | death (Item 23a) (Type, I OE CACA trar's Signature | arker | | / | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1:30 A Lawracy Wendorff March 2009 /Medical 5 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2**X** XF 164-12-2879 Director 91 July 13. 1917 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Wedical Event on the permitted at 1 ☐ Yes 2 → No Directo Maryland Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20723 U.S.A 8310 Honey Hill Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give XX 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: þ 3 Widowed 4 □ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f ment of Health and Mental George Paltanavich Catherine Kuklivies 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau 8310 Honey Hill Rd. Laurel, MD 20723 Richard Lawracy (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Clinton, MD 3-6-2009 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. Sign ture of Funeral Service Licensee M01555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed Examir burial-transit and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has I page 2 s autopsy 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 25 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending F 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and hi

State Registrar

Registrar MAR 0 9 2009

Registrar's Sendure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death . ^{Day} 2009 **Physician** Ruth Wirtner Weamer March 8, 3:28 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 122 Ponytail Lane Taneytown Carroll 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours 1 □ M 2 F 209-20-6922 81 Yrs June 4, Director 1927 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Examiner must be notified at 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Taneytown Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 122 Ponytail Lane 21787 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Wirtner Philip John Bauman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau 122 Ponytail Lane, Taneytown, MD 21787 Fred L. Weamer, husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of Scenterly, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Crematory 3/09/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDEO PULMONARY ARREST. /Medical Due to (or as a consequence of): **Examiner** CARDEAC ARRHYTHMEA Muletin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Months. Physician: The law requires that the death certificate be executed WING CANCER attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ NIDOM - Dinheter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Example: On the best of examination and/or investigation to provide the cause of the 29a. Certifie

To the Hospital or Attending Provinin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

JIL

State Registrar

Medical

29b. Signature and title

30. Name and address of person who

SAMUEL 1502 SOUTH MAIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and may ner stated.

MT. ARY.

29c. License number

ST.

D50207-

29d. Date signed (Month, Day, Year)

| | | | Ple | ease | Type or Prin | | | | | | | • | |
|----------------|--|---|--|---|--|-------------|---|--|---|---|---|-------------------------------------|--|
| | | | 1 - For State Registrar | | State of Ma | aryland | | artment of F <i>rtificate of</i> | | Mental Hy | | 0000 | 00100 |
| | 756 | | Registrar 1. Decedent's Name (First, Mi | ddle, La | st) | | | | Dealli | 2. Date of De | | 400 | 3. Time of Death |
| Н | Physicia /Medic | | Imogene | | М. | W | ise | | | Month March | Month March 2, 2009 1:35 A M | | |
| | Examin | | 4a. Facility Name (If not institu | | | | 4b. City, Town, or Location of Death Burtonsville | | า | | . County of Dea Montgome | | |
| - K | Funeral | | Sanctuary At Holy Cross 5. Social Security Number 6. Sex 7. Age (In yrs. la | | | | | last birthday) If Under 1 Year If Under 24 Hrs. | | | 8. Date of Birth 1945 9. Birthplace (State or For | | |
| | Director | Usual Residence of Decedent 223-62-7515 □Sual Residence of Decedent | | | | | | | | | ber | l Sale | em, Virginia |
| | Marylan I-f show fied at | by Funeral Director | MD 10b. Cou | nty tgon | nery | | , Town or Lo tonsvi | | e e | | | | 10d. Inside City Limits 1 Yes 2 No |
| | filed within 72 hours after death with the Maryland Hygione. Hher than "natural", or items 23a or 28a-f show nt, the Medical Examiner must be notified at | | 10e. Street and Number 3415 Greencas | t1e | Rd. | | 10f. Zip Code 20866 | | | | _ | izen of What Co USA | ountry? |
| | ems 2 | | 11. Marital Status 12. Was Decedent Example Forces? | | | Ever in U.S | 3. 13. | Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto | | pecify Yes or Note 10 Rican, etc.) | 0- | 14. Race - Ame Black, Whit | |
| 215-0036 | ours after ral", or it Examine | | 1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divord | | 1 ☐ Yes 2 🙀 N If Yes, Give Year or Dates: | 10 | 1 ☐ Yes 2 ☑ No Specify: | | | | | Specify: White | |
| <u>5</u> -0 | יח 72 ה "natu edical | letec | 15. Dece (Specify only hig | lent's Ed thest gra | ducation ade completed) | | 16a. Deced | lent's Usual Occup kind of work done OO NOT use retire | pation during most of wor d) | rking | 16b. K | ind of Business | /Industry |
| 212 | s within jiene. r than the M | To Be Completed | Elementary/Secondary (0-1: 12th | 2) | College (1-4or 5 | +) | | erty Mar | | | P | rivate | |
| Maryland 21 | be do | | 17. Father's Name (First, Middle, Last) Tom Jones 18. Mother's Nam Hazel | | | | | e (First, Middle, Maiden Surname) Foster | | | | | |
| Mary | ges 1 and 2 should t of Health and Men If Item 27 is marke or other traumatic | | 19a. Informant's Name/Relation Tammy Wise / | | Type. Print) aughter | | | | and Number or Ru , Brentw | | | or Town, State, 2 | Zip Code) |
| Baltimore, | Pages 1 and the sent of He int: If Item iny or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other | | | CE | meterv. crer | sition <i>(Na</i> me of natory or other pla Memorial | Park 3/ | Date 7/2009 | | cation - City or | |
| Balti | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Funeral/Serv | | 1 | K | | Name and Addre | ess of Facility J | | | | uneral Home 20011 |
| t | * K | | 23a Part1. Enter the disease shock, or heart failure. | or con | plications that caused one cause on each lin | the death | | | | | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Advantad Carbon Security Due to (or as a consequence of): | | | | | | | | | Oriset and Death | |
| E | Examiner | aminer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): | | | | | | | | | | |
| | be executed cian and curial-transit | | | | | | | | | | | | |
| 760, | e be exe sician a s burial-l | = | | | | | | | | | | | |
| 289 | rtificate ng phy s as the | Medic | IF FEMALE: | | - u. | | | | | | | | |
| O. Box | The law requires that the death certificate by the has been signed by the attending physici bage 2 should be detached for use as the bu | Physician/Medica | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Moo 9 ☐ Unknown | ecedent pregnant past 12 months? as 2 No 23c. If yes, outcome pr pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) | | | | | | 23d. Date of de Month | | livery Day Year | |
| ds, P.O | uires that is signed by Id be deta | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | oid tobacco use contribute to the cause of death? ☐ Yes 2☐ No 3☐ Probably 4☐ Chknown | | .72 | | |
| Vital Records, | ne law require has been się je 2 should b | e Completed | | | | | | | | 24a. Was | | 24b. Were an prior to death? | utopsy findings available completion of cause of |
| <u>ra</u> | sician: The law s certificate has t irector, page 2 s | | 25. Was case referred to med | ical | | | · | | 26. Place of Dea | 1□ Yes | ≥ No | | 2. No |
| | Physicia this cer al direct | To Be | examiner? 1 ☐ Yes 2 No | | Ho <i>s</i> pital: 1 ☐ Inpatie | nt 2□E | R/Outpatien | t 3 DOA Oth | or. | lome 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| Division or | inding Pt ath. ir: After the ie funeral | | 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | | | | | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | | | ry occurred | | |
| | al or Attend s after death al Director: | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | To the Hospital or Attending Physician: within L24 hours after death. To the Funeral Director: After this certification on properties of the completely filled in by the funeral director; p. | Medical (| 29a. Certifier (Check only one) | fying Ph cal Exar | nysician: To the best of miner: On the basis of and manner sta | examinat | vledge, death ion and/or in | occurred at the tivestigation, in my | me, date and place opinion, death occu | e, and due to the urred at the time | cause(s , date an |) and manner as d place, and due | s stated. e to the cause(s) |
| | To the withing of the the comp | M | 29b. Signature and title of cer | ifier | 225 | | | 29c. Licens | se number | 6 | 29d. Da | te signed (Mont | h, Day, Year) |
| Kp. | 21 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | 200-0- | | |
| 4 | Sta Registr | | Sunitha B 31. Date filed (Month, Day, Ye | ar) | 32. Registra | ar's Signat | ure | I'M Am | nw # 1 | -1+9 | 1 1 72 | אלארו | 1 20402. |
| | riegisti | a i | MAR 0 9 2009 | M | were p. | 190 | | | <u></u> | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 4:35 am Richard C. Waskey March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 M 2 □ F 213-32-2523 Director 74 May 16, 1934 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo MD Ellicott City Howard 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21042 USA 12625 Golden Oak Dr. by Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Self Employed Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be ဥ A. Calvin Waskey, Jr Margaret Tinley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 585, Ellicott City, MD 21041 Patricia Waskey / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Mem. Pk. 3-12-2009 Elkridge, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21. Sign yur of Funeral Service ndre 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) been signed by the should be detached 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 4 Unknown 1 ☐ Yes 2 ■ No 3 ☐ Probably Completed To the Hospital or Authority and the Funeral Director: After this certificate has been from the Funeral Director: After this certificate has been formeletely filled in by the funeral director, page 2 should be a supplied in the funeral director. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 Yes 2□ No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signati

(b)ao

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

WESHIWSter

23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #14 Pestate of Maryland Department of Health and Mental Hygiene 09-02028 Elizabeth White 1- For State Certificate of Death Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 12, 2009 0202 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salisbury If Linder 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. Director .50 Country) Usual Residence of Decedent 10a. State 10b. County Town or Location any 1 Yes 2 No hours after death with the Maryland Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Numb 2180 Funeral 14. Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. White Armed Forces' Yes Divorced If Yes, Give Year Yes 2 No specify: 3 Widowed 4 'natural", 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "1 r other than "1 MD 21215-0036 0 18.Mother 's Name (First, Middle Father's Name (First, Middle, Last Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19b. Mailing Address Mationship (Type, Print) Sistel 20c. Location - City or Town, State Baltimore, I permit Pages I and Department of Healt Important: If item Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Burial 2 Premation 3 Other Specify: Donation 5 22. Name and Address of Fa 21. Signature of Funeral Service Licensee per DVR Michael Thomas Scott, Sr. (M01335) 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and for use as the burial - transi To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical #21 per FD g889 3/24/09 X UNPENDED AMENDED 23a,2<u>7,perME</u> Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes Yes 2 2 No 26.Place of Death (Check only one 25 Was case referred to medical Other; examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 FR/Outpatient 1 V Yes After this No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 27, Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Fo the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E March 12, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Re istrar's Signature State

DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 05 PM MARCH Neola Ottalyn Suzanne Otto Young 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death CHARI ENTER IVISTA MEDICAL If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🖫 F Min. 100 543-54-8763 October 23,1908 Oregon Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🎇 No Cobb Island Marvland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15435 Potomac River Drive 20625 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify White Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Fredrick Otto Minerva Buehler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Chalker/Daughter 15435 Potomac River Drive Cobb Island, Maryland 20625 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State March 8,2009 Charlotte Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 21. Signature of Puristal Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Hôme, P.A. M01458 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cute disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Pheumonia resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2'ÛNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, certificate this

physician and s the burial-trans attending ph for use as the detached cate has been signed by page 2 should be detacl funeral director, After death. the within 24 hours after death To the Funeral Director: filled in by Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō items 23a

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"natural"

1 and 2 should be filed wi Health and Mental Hyglen em 27 is marked other th

permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra once. of Health

Physician

/Medical

Examiner

ງວາງ ທອງໄຂວໄດ້ (ທີ່ວິດ) Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ပ

Examiner

Physician/Medical

2

Completed

Be

Certification: To

traumatic event, the Medical Exeminer must be notified at

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural
2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Medical 29b. Signature and title o certifier

09

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr, Ste 103 Waldorf 11637 MD lanisha lervace Janwala 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

completely

| | | | 1 _ State | artment of Health and Mental Hygiene | | | | | | |
|------------|---|-------------------------------|--|---|--|--|--|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | 2. Date of Death 3. Time of Death | | | | | | |
| н | Physici /Medio | | Loring Bernard Yingling | March 6, 2009 1:20 PM | | | | | | |
| | Examir | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death Westminster 4c. County of Death Carroll | | | | | | |
| - | Funeral | | Carroll Hospital Center 5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) | | | | | | | |
| п | Funeral Director | Н | 217–16–4609 11♥M 2□F 90 Yrs. | y If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Dec 30, 1918 Maryland | | | | | | |
| | and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L | ocation 10d. Inside City Limits | | | | | | |
| | Maryl | tor | Maryland Carroll | Westminster 1 [™] Yes 2□No | | | | | | |
| | or 282 | Direc | 10e. Street and Number | 10f. Zip Code 10g. Citizen of What Country? | | | | | | |
| | s 23a | eral | 205 St. Marks Way, Apt 318 | USA | | | | | | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if it Modicial Evar, incr. just by notified at Once. | Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give WWII Year or Dates: | Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: white | | | | | | |
| 5-0 | 72 ho "natur | etec | (Specify only highest grade completed) (Give | edent's Usual Occupation 16b. Kind of Business/Industry | | | | | | |
| 121 | within iene. than | dwo | Elementary/Secondary (0-12) College (1-4or 5+) | irman of the Board Insurance Co | | | | | | |
| | e filed al Hyg other vent, | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Middle, Maiden Surname) | | | | | | |
| ylaı | ould b Ment narked natic e | 10 | Tobias Yingling | Ruth H. Nusbaum | | | | | | |
| Maryland | nd 2 sh Ith and 27 is n | | | ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Marks Way, Apt 318, Westminster, MD 21158 | | | | | | |
| Jre, | of Hea | | 20a. Method of Disposition 20b. Place of Disp | osition (Name of part of the place) Date 20c. Location - City or Town, State | | | | | | |
| Baltimore, | . Page tment tant: If jury o | | 4 Donation 5 Other (Specify) | t Valley Cem 03/10/2009 Westminster, MD | | | | | | |
| Bal | permit Depar Impor any in | | 21. Signature of Funeral Service Licensee | Name and Address of Facility Myers—Durboraw Funeral Home No. 1 Willis Street, Westminster, MD 21157 | | | | | | |
| | Physician /Medical | i i | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. | nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death | | | | | | |
| | | | Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYO CARDIAL INFARCTION Due to (or as a consequence of): CORONARY ARTERY DISEASE | | | | | | | |
| | Examiner | , | Sequentially list conditions, b. CORONARY ARTERY DISEASE | | | | | | | |
| | ted nsit | Examiner | ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events see life aid education of the cause | | | | | | | |
| ó | icate be executed physician and the burial-transit | Exar | that initiated events c. resulting in death) Last C. Due to (or as a consequence of): | | | | | | | |
| 68760, | ate be | dical | d | | | | | | | |
| 9 X | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit | | IF FEMALE: 23c. If yes, outcome of pregnancy | 00d Duty 4 d r | | | | | | |
| . Box | death e atter d for u | Physician/M | in the past 12 months? 1 | ☐ Ectopic pregnancy ☐ Other (specify) | | | | | | |
| P.0 | at the | Phys | 9 ☐ Unknown | | | | | | | |
| ds, | uires that the de signed by the a d be detached f | by | Part II. Other significant conditions contributing to death but not resulting in the URINARY TRACT INFECTION | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝Unknown | | | | | | |
| Records, | w requir s been s should | letec | RENAL INSUFFICIENCY | 24a. Was an 24b. Were autopsy findings available | | | | | | |
| Be | The law ate has bage 2 s | Completed | 7,07,4712 7,490477 100 | autopsy prior to completion of cause of death? 1 □ Yes 2 □ No | | | | | | |
| Vital | ysician: The I is certificate ha director, page | Be C | 25. Was case referred to medical examiner? | 26. Place of Death (Check only one) | | | | | | |
| of | Physic rthis cral dir | 7: To | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of | - I delicated to Electrical (Openiny) | | | | | | |
| ion | nding Phy ath. r: After thi e funeral (| ation | 1 Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation | M 1 Tyes 2 No | | | | | | |
| Division | or Atte ter dez irecto n by th | Certification: To | 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural building, etc. (Specify) City or Town, State) | | | | | | | |
| Ω | pital o | | 29a. Certifier 15 Certifying Physician: To the best of my knowledge, dear | th occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | |
| | n 24 h | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. | nvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | |
| | To the Hospital or Attending Powiting 42 within 24 hours after death. To the Funeral Director: After to completely filled in by the funera | ž | 29b. Signature and title of certifier | 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | |
| | WJL | | A. J. Helay, M. A | DO011673 Wanch 6, 2009 | | | | | | |
| | AVITOI | | 30. Name and address of person who completed cause of death (Item 23a) (Type, ABDALLAH J. HELOU, M. J. CARROLL M. | Print) POSPITAL CENTER WESTMINSTER, MD 21157 | | | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | hade | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Zerphey Mary 28, 2009 3:12 A Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F 87 558-24-2313 Director California Aug. 10,1921 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Exercitor must be notified at MD Anne Arundel Arnold Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 23a or 21012 USA 881 Windsong Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🕱 No Specify: White Specify: ≥ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 1 and 2 should be filed wi Health and Mental Hygier om 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Apolonio Trujillo Susan Agilar ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is: any injury or other traus Robert G. Zerphey / Husband 881 Windsong Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 06, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery Crownsville, MD 2009 Barranco & Sons, P.A. Severna Park Funeral H 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part/. Enter the disease, or complications that obused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final myocardia **Physician** acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Month Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 I Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Hospital or Attending Physician: The certificate 2 🗆 No Division of Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No n 24 hours after death.
e Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the the within 7

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 05 2009

Registrar's Signat

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death rst. Middle, Last) Decedent's Na 23 AM Dav Year Month **Physician** WW OOC 00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto Cromwell Nursing Center Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Months Director 2-14-1949 60 238-82-6898 N.C. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other then "natural", or Itams 23e or 28e-f show other treumetic event, the Medical Exeminer must be trutified at MD N/A Baltimore XX es 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 S A Funeral 1 Avenue 12. Was Decedent Ever in U.S. Armed Forces? 5617 Biddison filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Tractor Trailer Driver 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental H 7 is markad ot Ellen Wilson 2 William Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If itam 27 is Rhonda Adams-Wife 5617 Biddison Avenue Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ō permit. Page Department o Importent: If 3-24-2009 Baltimore, MD Garden of Faith * 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue 20 CA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month jo in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ned by the a e detached f 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, sign. be c þ 1 TYes 2 No 3 Probably 4 DURKnown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 🗌 Yes Firsing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No dealth. investigation 2 Accident within 24 hours at er deal To the Funaral D rector; the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ir by 4 Homicide Contriving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signal a and title of certifier 29c. License number ath (Item 23a) (Type, Print) 505 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Clarence Armstrong 1725 PM March 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltmore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) XIXM 2□ F Director 73 249-52-3107 S C 7-30-1935 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show at of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Wedical Event has a ust by notified at Director 1XYes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2631 Northshire Drive Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23 21230 U S 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1√Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes X□XNo Black þ 3 ₩ Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Trailor Driver Tractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Armstrong ٩ Azalle Bird 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Armstrong-Daughter 2631 Northshire Drive Balto, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any Injury or ot once. Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Zion Cemetery 3-28-2009 Lansdown, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 21202 1101 E. North Avenue Baltimore, 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 duys meumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ should I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has be rector, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 □Yes 2 **N**o 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi Medical and manner stated

State Registrar

Ryan 31. Date filed (Month, Day, Year)

Arnold

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32 Registrar's Signature MAR 2 4 2009

22 S. Greene

29c. License number

22054

St Baltimore, MD

29d. Date signed (Month, Day, Year)

Amend #3 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8890 4/14/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrat Reg. No LU Certificate of Death 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Thomas Wilkinson Atwell March 19 2008 .15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hospital Center Cheverly Prince <u>George's</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months 1 ☑ M 2 □ F Director 03/13/1933 219-30-4623 Kentucky Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County show 77 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Exemition must be inclined at MD Howard Fulton 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8020 Hunterbrooke Lane 20759 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X es 2 No 1952 Fees or Dates: 1956 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Estimator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Richard Nelson Atwell Ethel Mae Layton t and 2 should be Health and Ment 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey W. Atwell/Son 8332 Mary Lee Lane, Laurel, MD 20723 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 iment of H 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 03/23/2009 Hanover, Maryland Ardent Cremation Services 📒 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ar lent Cremation Services 21. Signature of Funeral Service Licensee 50A 7522 Connelley Drive, Ste. N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Recurrent Sepsis **Physician** 4 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure 6 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Exami Heart Failure 6 Months Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus Completed Hypertensive Cardiovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Respiratory Failure this certificate 2 □ No 1 ∐Yes 2 🕅 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours I ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ertifying Physician: 10 the basis of each manner state Medical (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur D 16273 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy, 6130 Landover Rd., Cheverly, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 žŏ March Esther A. Allender /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 820 Orems Road 8. Date of Birth (Month, Day, Year) Sept. 26, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 3 F 215-28-8962 77 MD **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any liury or other traumatic event, the Medical Exymirar must be notified at agnes. Once. 10a State Middle River Baltimore MD Director 1 ☐ Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 820 Orems Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Specify: White 2 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hester McCalister Howard Ewing ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edgar Lee Allender Jr 820 Orems Road Baltimore MD 21220 /son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory 3/24/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Se vice Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Kolub Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or composhock, or heart failure. List only of ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **♣** Physician Henal lears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SOCZ Atheroscleros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown P.0. detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director; After t Certification: 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certification 30. Name and address of completed cause of death (Item 28a) (Type, Print) person who MICHAELSUTER Parkville MO 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kae Alessi-Majer **Physician** 5:05: M 2000 MARCH 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore 8. Date of Birth (Month, Day, Yea March 16, 5^{Year)}1947 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**X** 62 Illinois 358-42-8880 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Expandrer must be notified at Baltimore 1XXes 2 □ No Director MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1721 Gough Street 21231 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes ŽXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 XX arried 1 ∐Yes 2 XXXo Specify. White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, If a Mental Injury or other traumatic event, Item Men Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Assistant Manager 5+ 17. Father's Name (First, Middle, Last) Marion Woods 18. Mother's Name (First, Middle, Maiden Surname) Be Astrid Johnson ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) Gerald Majer (Husband) 1721 Gough Street Balto, MD 21231 Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 3/23/09 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 21211 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINGNA 4 YEARS Physician METASTATIC BREAST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEIZURE DISOLDER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examine law requires that the death certificate be executed DEHUPRATION and the burial-tran Due to lor as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 →No ed by the a P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Physiclan; The 2 110 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1 Yes 2 ₩o 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To this After thi funeral 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MEMORIAL

M.D.

MION

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSKINS, MO

29c. License number

AT 2438946

HOSPITAR, BALTMONE MARYLAND

29d. Date signed (Month, Day, Year)

(YIANUT 18, 2000

| | | | State of Mar | | | | Mental Hy | giene | 001!! | |
|---------------------|---|---|---|--|--|---|--|--|--|--|
| | _ | 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Dea | 3. Time of Death | | |
| | Physici | | Venon P. Benur | | | | Month 3 | Day Year | 1100 | |
| A | /Medio | | 4a. Facility Name (If not institution, give street and number) | 3 | 4b. City, Town, or | r Location of Deatl | | 4c. County of Dea | | |
| - | | | University of Maryland 5. Social Security Number 6. Sex 7 7. Age (| In continue to the design of t | 15 alt | More C If Under 24 Hrs. | ity | h | 1411 | |
| | Funeral Director | | | In yrs. last birthday) 72 Yrs. | Months Days | Hours Min. | 8. Date of Birt (Month, Da 7/6/193 | y, Year) 9. Bl | rthplace (State or Foreign ountry) ryland | |
| | pur 🚜 | | Usual Residence of Decedent 10a. State 10b. County 16 | Oc. City, Town or Loc | cation | | | | 10d. Inside City Limits | |
| | Maryla f sho | tor | | nottingham | | | | | 1 □Yes XXNo | |
| | or 28a | Director | 10e. Street and Number | | 10f. Zip Code | | | 10g. Citizen of What C | ountry? | |
| | ath wit | rai | 9505 Gunview Rd. | | 21236 | | | United Sta | tes | |
| | items iner | Funeral | 11. Marital Status 12. Was Decedent Eve Armed Forces? 1 □ Never Married 2 ▼ Married 12. Was Decedent Eve Armed Forces? | r in U.S. 13. W | Vas Decedent of H f Yes, specify Cuba | lispanic Origin? (S an, Mexican, Puert | pecify Yes or No- o Rican, etc.) | 14. Race - Am Black, Whi | erican Indian, te, etc. | |
| 036 | al", or | þ | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 | □Yes 2No | Specify: | | Specify: | White | |
| 15-0 | filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mydical Everging mast be notified at | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give k | lent's Usual Occup | during most of wor | king | 16b. Kind of Business | /Industry | |
| 72 | within liene. than | ошо | Elementary/Secondary (0-12) College (1-4or 5+) | Build | 00 NOT use retired ^ | 1) | | Constructi | on | |
| ba | e filed al Hyg I other vent, | To Be Co | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nan | | Maiden Surname) | 511 | |
| ylaı | ould b I Ment narked natic e | | Arthur L. Benway | | | | . Nodine | | | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Everained mast be notified at once. | | 19a. Informant's Name/Relationship (Type. Print) Mrs. Margaret Ann Benway (wi | fe) 9505 | g Address <i>(Street a</i> Gunview | and Number or Ru Rd. No | ral Route Numbe ttingham | or, City or Town, State, , Maryland | Zip Code) 21236 | |
| Baltimore, | es 1 a of He of He or othe | | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State | 20b. Place of Dispos cemetery, crem | sition (Name of natory or other place | | Date | 20c. Location - City or | Town, State | |
| ij. | t. Pag rtment rtant; I | | 4 Donation 5 Other (Specify) | Parkwood | - | | 3/2009 | Parkville | , Maryland | |
| Ba | perm Depa Impo any I | | 21. Signature II Fureral Service Licensee | | Name and Address | | 5305 | Harford R | d. | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. | e death. Do not ente | er the mode of dyin | g, such as cardiac | or respiratory ar | Baltimor | , AD 21214 Interval Between | |
| 4 | Physician | | Immediate Cause (Final disease or condition | | | | | | Onset and Death | |
| 1 | /Medical Examiner | | resulting in death) Due to (or as a co | onsequence of): | | | | | | |
| | ± 0 | Examiner | Sequentially list conditions, if any, leading to immediate cause. First fundoring to immediate cause. | | | | | | | |
| | ecute and I-trans | | Cause (Disease or injury that initiated events c | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | dical E | d d | macquerice ory. | | | | | | |
| 89 | rtificat ng phy as the | Medi | IF FEMALE: | | | | | | | |
| Box | leath certific attending p for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | | | | | | 23d. Date of delivery Month Day Year | |
| P. 0 | at the de by the stached | hysic | | | | | | | | |
| ς. Π | uires that signed t d be deta | þ | Part II. Other significant conditions contributing to death but n | ot resulting in the un- | derlying cause give | en in Part I. | 23e. Did to | bacco use contribute t | o the cause of death? | |
| Records, | w requir s been s should | | | | | | 1 U Y | es 2□No 3□P | robably 4 🗗 Unknown | |
| Bec | he law e has l ige 2 s | Completed | | | | 7-47 | 24a. Was a autops perfor | sy prior to | utopsy findings available completion of cause of | |
| Vital | sician: The certificate h rector, page | Be C | 25. Was case referred to medical | | | 26. Place of Dea | 1 □Yes | | s 2 □No | |
| <u>></u> | Physic r this ce ral direc | 일 | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient | 2 ER/Outpatient | | er: 4 🗆 Nursing H | | ence 6 ☐ Other (Spe | ecify) | |
| uc | ding P h. After funera | ü | 27. Manner of Death 28a. Date of Injury (Month, Day, Ye (Month, Day, Ye (Decident investigation | ear) 28b. Time of Injury | 28c. Injury Work | yat :? Yes 2∐No | 28d. Describe h | ow injury occurred | | |
| Division of | tal or Attanding Physician: rs after death. al Director: After this certifice ed in by the funeral director. | Certification: | - Da 111 | - At home, farm, stree Specify) | | 162 2 1140 | | treet and Number or R | ural Route Number, | |
| هٔ | 교환하 | Cert | | n, State) | | | | | | |
| (| To the Hospital within 24 hours a To the Funeral completely filled | edical | 29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 2 Medical Examiner: On the basis of examiner and manner stated | amination and/or inv | occurred at the tin estigation, in my o | ne, date and place pinion, death occu | , and due to the or rred at the time, o | cause(s) and manner a date and place, and due | s stated. e to the cause(s) | |
| | To the within 2 To the сощр!е | Me | 29b. Signature and fittle of certifier | | 29c. License | number | 2 | 29d. Date signed (Moni | th, Day, Year) | |
| | | | Ma Ci for | - | 1817 | 5 | | 3/15/09 | | |
| | | | 30. Name and address of person who completed cause of death | h (Item 23a) (Type, P | Print) | o Chica | -L Da | 140 mm | 21201 | |
| | Stat | e | 31. Date filed (Month, Day) 32. Registrar | Signat | JUL - EIO | 11166 | 7 1017 | וויוןטוי | | |
| | Registra | ar | MILITIN X Z ZOOO | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09145 For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Laura May Bauer 2Ö 2009 09:15 aM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 ☑ F 504-18-0442 93 December 21, 1915 Colorado Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A BAltimore 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 IISA 5203 Tramore Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕱 No Specify ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Benson Charles Byers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3410 Dublin Road Darlington, Maryland 21034 Charles Bauer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/23/09 Towson Maryland Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVASCULAR ACCIDENT. Immediate Cause (Final disease or condition resulting in death)

Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after annet of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or iten any or other traumatic event, the Medical Examinent ury or other traumatic event, the Medical Examinent.

permit. Pages Department of H Important: If ite any injury or of

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

Be

2

death with the Maryland

| Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of): C. Due to (or as a consequence of): | | | | | |
|---|--|--|---|--|---|--|--|
| ysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 9 □ Unknown | | 23d. Date of delivery Month Day Year | | | | |
| ed by Pi | Part II. Other significant conditions of | ontributing to death but not resulting in the underly | 23e. Did tobacc | o use contribute to the cause of death? 2☑No 3☐ Probably 4 ☐Unknown | | | |
| Complet | | | | 24a. Was an autopsy findings av prior to completion of cau death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No | | | |
| Be | 25. Was case referred to medical examiner? | | 26. Place of Death (| Check only one) | | | |
| 0 | 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 | DOA Other: 4 Nursing Home | e 5 🗆 Residence | 6 ☐Other (Specify) | | |
| ation: T | 27. Manner of Death 1 | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M | 28c. Injury at Work? 28 | 28d. Describe how injury occurred | | | |
| Certific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injury - At home, farm, street, fa building, etc. (Specify) | actory, office 28 | and Number or Rural Route Number, ate) | | | |
| Medical Certification: | 29a. Certifier 1 Certifying Phyone 2 Medical Exam | ysician: To the best of my knowledge, death occu niner: On the basis of examination and/or investig and manner stated. | urred at the time, date and place, ar ation, in my opinion, death occurred | nd due to the cause d at the time, date a | n(s) and manner as stated. and place, and due to the cause(s) | | |
| Σ | 29b. Signature and title of certifier | | 29c. License number | 29d. [| d. Date signed (Month, Day, Year) | | |
| | 1 Cofon. | Awuch | D0061789 MARCH, 20, 200 | | | | |

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a

LORRAINE OFORI-AWUAH, 5430 CAMPBELL BLVD, STE 214, BALTIMORE NO 21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 2 4 2009

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Time of Death 18^{Day} 2009 Year **Physician** MARCH 11:02 P M Bettye Anne Bachran /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWSON BALTIMORE GREATER BALTIMORE MEDICAL CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Year) Days Hours 1 M 2 F Aug. 27 1926 MD 82 214-22-8117 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 28a-f show injury or other traumatic event, the Medical Exercitive must be notified at 1 ☐Yes 2 ☐ No Director Towson MD **Baltimore** 10g. Citizen of What Country? 10e Street and Number 21286 USA 219 Linden Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 11 Marital Status 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. white Specify. 3 XWidowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Executive Secretary** Insurance/Auto Parts 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian I. Miller William N. Harrison ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lester W. Bachran, Jr./son 1143 Fairbanks Dr., Lutherville, MD 21093 permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/21^D709 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serve 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, Inc. W. Padonia Rd., Timonium, MD 21093 Michael 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) discase **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Эна to for early eoneschense off Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) sate has been signed by the page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes Νo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe After this certificate 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner?
1 ☐ Yes Z No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Monjh, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Avil F. Grenzer, M.D. 6569 N.Ch. les St. #600 B. Hime-C

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Registrar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2:56 Physician Bury arles march /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Johns Hopkins Bay View Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Months Hours 1**X** M 2 □ F 11-17-1955 MD Director 53 Unknown Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Modical Evantical must be notified at 1 ¥ Yes 2 □ No Director Dundalk Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Clair Lane 21222 7855 St. by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive <u>Mechanic</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Blank Charles R. Bury, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health a permit. Pages 1 and Department of Health Important: if item 27, any injury or other tra once. Jennifer Meadows - Daughter 7816 St. Bridget Lane, Dundalk, MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 3-23-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Failure Immediate Cause (Final Respiratory 10 minutes Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Iweek Examiner Bacterial Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead to the cause). Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\bigcap \) Nursing Home \(5 \bigcap \) Residence \(6 \bigcap \) Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation neral Director; / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Res-000

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Brian Hours MD 4940 Eastern Ave. Baltimore, MD 21224 . Registrar's Signature

| | | | For State | State | of Maryland | | artment of H | | • | _ | 000 | 0011.0 |
|---------------------|---|----------------|---|---|--|-------------------------------|--|-----------------------------|-----------------------------|---------------------------------------|--------------------|---|
| | | | Registrar 1. Decedent's Name (First, Middle) | llo (act) | | Cei | lineale of L | Jealii | 2. Date of De | Reg. No. Z | 009 | 3. Time of Death |
| Н | Physicia | | Reister | | sell | В | ollinger | Jr. | Month | Day | 2009 | 0845M |
| ich. | /Medic Examin | | 4a. Facility Name (If not institution | (3) | umber) | | 4b. City, Town, or | | ath | 4c. Co | unty of Death | 2_ |
| , | | | Tou MAY | YO Ka | | | Colen | | uire- | | HIV | |
| н | Funeral | | 5. Social Security Number 220–48–4722 | 6. Sex 1 ☑ M 2 ☐ F | 7. Age (In yrs. la | a <i>st birthday)</i> Yrs. | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | | th av. Year) 7 - 1947 | , 9. Birthp | lace (State or Foreign htry) MD |
| | Director | | Usual Residence of Decedent | | 01 | | | | Dec. 2 | ,,1517 | | 1115 |
| | ylanc how | | 10a. State 10b. County | 1 | 10c. City | , Town or Lo | cation | _ | | - | 11 | 0d. Inside City Limits |
| | e Mai | Director | MD Anne | Arunde1 | | Glen B | | | | | | 1 □ Yes 2 No |
| | if the | Dire | 10e. Street and Number | | | | 10f. Zip Code | | | | of What Coun | itry? |
| | ath w s 23a | sral | 704 Mayo Road | 10 14 | and the state of t | 140 | 21061 | | (Charify Van ex Na | U.S.A | Race - Americ | on Indian |
| | item item | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Mar | Armed F | cedent Ever in U.S orces? 2 \(\) No | . 13. | Was Decedent of H If Yes, specify Cuba | in, Mexican, Pue | erto Rican, etc.) | | Black, White, e | etc. |
| 936 | urs aff | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes. G | iive | | 1∐Yes 2∭ANo | Specify: | | Sp | ecify: Whi | te |
| Ö ol | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Exondher is ust be notified at | sted | 15. Deceder | nt's Education est grade completed | , | | dent's Usual Occup | | orkina | 16b. Kind | of Business/Inc | dustry |
| 2 | | Completed | Elementary/Secondary (0-12) | | (1-4or 5+) | life. | DO NOT use retired | () | oming . | | | |
| 2 | filed within Hygiene. other than " | ပိ | 1.2 17. Father's Name (First, Middle, | (act) | | Fore | man | 18 Mother's N | ame (First, Middle | | ruction | ii. |
| Maryland 21215-0036 | 2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M |) Be | Reister R. Bol | | | | | | a Davis | , maden oa | marrie) | |
| Ž | should be f and Mental is marked of sumatic eve | ပ | 19a. Informant's Name/Relations | | | 19b. Mailir | ng Address (Street | and Number or i | Rural Route Numb | er, City or To | own, State, Zip | Code) |
| | 1 and 2 : Health a tem 27 is | | Gail A. Bollin | nger/wife | | 704 | Mayo Roa | d Glen | Burnie, | MD 210 | 061 | |
| altimore, | permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once. | | 20a. Method of Disposition | о П в | 20b. Pi | ace of Dispo | sition (Name of matory or other plac | e) Mar | ch 24, | 20c. Locat | ion - City or To | wn, State |
| <u><u>Ĕ</u></u> | Pages ment of I ant: If ite ury or o | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 | | | yland | Vets. Ce | m. 20 | 09 | | sville | |
| Balt | permit. Pag Department Important: I any Injury o | | 21. Signature of Funeral a rvice | Licensee | | | 2. Name and Addres | | | | | |
| | 0.0 = 0 0 | | 141 | | 0122C | | | | | | BUTRI | e, MD 21061 Approximate |
| | | 8 16 | 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final | t only one cause | each line. | . Do not em | ter the mode of dyli | 0 | (-11 | A | | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. 171 | Coras a consequi | ence of: | dipe | JV | policyth | m 11 | 7 | |
| 1 | Examiner | | | Ar | terius | alone | tie k | leart | Dise | PAS | e | |
| | 7 + | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | o (or as a consequ | ence of): | , | | - 12 | - | | |
| | ecute and transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | C | | | | | | | | |
| 8760, | certificate be executed iding physician and se as the burial-transit | | resulting in death) Last | Due to | o (or as a consequ | ence or): | | | | | | |
| 687 | ficate physics from the l | edical | | d. | | | | | | -, | | |
| Box (| eath certific attending p for use as | J/Me | IF FEMALE: 23b. Was decedent pregnant | | utcome of pregnar | | 7 | | | 230 | I. Date of delive | ery |
| | death ie atte | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | | e birth 2 Tetal gnant at time of de | | ☐ Ectopic pregnanc ☐ Other (<i>specify</i>) _ | У | | | Month | Day Year |
| P. 0 | at the de I by the stached | hys | 9 🗆 Unknown | | | | | | 00 011 | | | |
| Š, | law requires that the death as been signed by the atter 2 should be detached for u | by | Part II. Other significant condit | ions contributing to | death but not resu | iting in the u | nderlying cause giv | en in Part I. | | Yes 2 1 | | ne cause of death? |
| Š | w requir been s should | eted | | | | | | | - [| | | |
| Records, | e - e | Completed | | | | | | | 24a. Was auto perfe | | prior to condeath? | psy findings available mpletion of cause of |
| Vita | ician: Th certificate ector, pag | | 25. Was case referred to medica | al | | | | 26 Place of D | 1 ☐ Yes eath (Check only | 2 No | 1 □Yes | 2 No |
| | ysician: is certific director, | To Be | examiner? 1 DYes 2 □ No | Hospital: 1 | Inpatient 2 🗆 I | ER/Outpatie | nt 3 DOA Oth | | | | Other (Specif | (y) |
| D 0 | iding Phys th. After this funeral dir | T:uc | 27. Manner of Death 1 Natural 5 ☐ Pendi | (8.4.0 | e of Injury onth, Day, Year) | 28b. Time o Injury | f 28c. Injur Wor | | 28d. Describe | how injury o | ccurred | |
| Sio | Attendi death. ctor: A y the fu | cati | | tigation | | | | Yes 2 □ No | 001 1 | · · · · · · · · · · · · · · · · · · · | | |
| Division of | il or Attend after death Director: d in by the f | Certification: | | mined Zoe. Place | ce of Injury - At ho ding, etc. (Specify | me, tarm, sti | еет, тастогу, опісе | | | wn, State) | lumber or Hura | al Route Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director; it | | 29a, Certifier 1 Certify | ing Physician: To that Examiner: On the | ne best of my know | wledge, deat | th occurred at the ti | me, date and pla | ace, and due to the | cause(s) ar | nd manner as s | stated. |
| | the Horizania 24 the Fu | Medical | one) | and ma | inner stated. | ilon and/or ii | 101 | | correct at the time | | | |
| | 5 with 5 CO | 2 | 29b. Signature and title of certific | er or | 7 | epu | 29c. Licens | e number | 054 | 29d. Date s | igned (Month, | G rear) |
| | | | 30. Name and address of person | n who completed == | les of doubt /learn | 23a\ /Time | Print) | | | U | 1-1 | 17 |
| +1 | | | William | RUJO | ones, | mo | 695 | Am | nerie | A d | 2103 | 15 |
| | Sta | | 31. Date filed (Month, Day, Year | r) 32. | Registrar's Signat | That | | | | | | |
| | Registr | ar | MAK 2 4 ZU | NO METERS | " " | - | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Phyllis March 2009 10:00 PM Mae Bolton 16) County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mil Baltimore Washington Medical Center 120 KNY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Year) 1 □ M 2 🖾 F Months Days Hours Min. 88 220-07-0513 March 17,1920 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8367 West B&A Road 21144 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Stevenson Cosand Bertha Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Terry Hatch /Friend 8369 W. B&A Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signatu Funera Service Licensee Servcies PA 1 2nd Ave. SW Glen Burnie, MD 21061 1012 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final in mo disease or condition resulting in death) Que to (or as a consequence of): distage O 0 man and Due to (or as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 N No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eximiner must be notified at once.

Baltimore, Maryland 21215-0036

s after dea... within 24 hours a To the Funeral D completely filled i

or Attending Physician; The law requires that the death certificate be executed

After this

Division of Vital Records,

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🗖 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide tiscertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certified

State Registrar

the Hospital

31. Date filed (Month, Day, Year! 32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print

Name and address of pe

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

| | | | 1 - For State Registrar | State of Ma | ryland / Depa <i>Cei</i> | artment of He Tificate of L | | | ene | 9 09152 |
|----------------------------|--|----------------|--|--|--|--|--|---------------------------------------|----------------------------|---|
| | | | Decedent's Name (First, Middle, Last) |) | | | | 2. Date of Death | | 3. Time of Death |
| | Physicia /Medic | | Bettv | Mari | e Cobu | rn | | Month March 2 | Day Y | 8:52A M |
| | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of I | Death |
| | } | | | Multi-Car | | Balt If Under 1 Year | imore If Under 24 Hrs. | O Date of Dish | N/A | District (Ohne Finish |
| -15 | Funeral Director | | 5. Social Security Number 6. Sec. 1218–26–1741 | M 257F 7. Age | (In yrs. last birthday) 94 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, Feb. 1. | Year) | Birthplace (State or Foreign Country) Marvland |
| | g | | Usual Residence of Decedent | | | | | rev. I, | 1910 11 | lar y Land |
| | anylan show | <u>.</u> | 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | he M | Director | Maryland N/A | | Baltimore | 104 7:- 0-4- | | 10 | Cities of Min | 1 X Yes 2 No |
| | with t | | | et Room | 157 | 10f. Zip Code 212 | 11 | 10 | g. Citizen of Wha | S.A. |
| | death me 23 | Funeral | 700 W. 40th Stre | 12. Was Decedent E | ver in U.S. 13. V | Was Decedent of His | spanic Origin? (Spe | city Yes or No- | 14. Race - | American Indian, |
| စ္ | or Ite | Fur | 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 ☐ Yes 2 X N If Yes, Give | 0 | f Yes, specify Cubar I□Yes 2□ (No | Specify: | Rican, etc.) | | White, etc. |
| 21215-0036 | 72 hours after death with the Maryland natural; or Iteme 23a or 28a-1 ehow disal Examinar must be notified at | d by | 3 Widowed 4 □ Divorced | Year or Dates: | | | | | Specify: | White |
| 15 | 15. Decedent's Education 15. Decedent's Grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) | | | | | | uring most of works | ng 1 | 6b. Kind of Busin | ess/Industry |
| 212 | Elementary/Secondary (0-12) College (1-4or 5+) | | | | | | | | Own | Home |
| br | e filed al Hygi other vent, | Bec | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Name | (First, Middle, M | | Troine . |
| ylaı | should be ind Mental marked o | To | Joseph | Kerns | | | Jo | sephine | F1€ | etcher |
| Maryland | 2 short and in a | | 19a. Informant's Name/Relationship (T) | pe, Print) | 19b. Mailin | g Address (Street a | nd Number or Rura | l Route Number, | City or Town, Sta | ite, Zip Code) |
| | es 1 and 2 should b of Health and Ment: I Item 27 ie marked r other traumatic e | | Beverly Cuba F 20a. Method of Disposition | riend | 2 Br | adford Col | urt Wic | hita Fal | 1s, Texa | v or Town State |
| nor | ages ant of t: If it | | 1 ☐ Burial 2 ⑦ Cremation 3 ☐ F | | cemetery, cren | natory or other place | 1 | 4. | | |
| Baltimore, | permit. Pages Department of I Important: If it eny injury or of | | 21. Signature of Pun val Service licens | | Hilltop Se | ETVICE CO: . Name and Addres | 15 0 | | owson | Maryland |
| ä | Depariment Deparement of the parement of the p | | Haules Ha | jan | | 1050 York | Road T | owson, M | | 1 Home, Inc. 21204 |
| | | | 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or | ications that caused ne cause on each lin | the death. Do not ente | | | | | Approximate Interval Between |
| 1 | Physician | | Immediate Cause (Final disease or condition | | Onset and Death | | | | | |
| | /Medical Examiner | | resulting in death) | Due to (or as a | consequence of): | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate | Due to (or as a | consequence of: | | | | | |
| | uted d ansit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | |
| Ó, | e exection and arrial-tr | Exa | resulting in death) Last | Due to (or as a | consequence of): | | | | | |
| 8760, | cate be executed physicien and the burial-transit | dlcal | | 1. | | | | | | |
| Ψ | ding p | /Me | IF FEMALE: | 3c. If yes, outcome of | of oregnancy | | | | | |
| Вох | death certific e ettending p id for use as | Physician/Me | in the past 12 months? | 1 ☐ Live birth 2 4 ☐ Pregnant at t | 2 ☐ Fetal death 3 ☐ | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | Day Year |
| P.O. | 0 0 0 | hys | 1 Yes 2 No 9 Unknown | 9☐ Unknown | | | | | | |
| | The law requires that the site has been signed by the bage 2 should be detache | by P | Part II. Other significant conditions con | ntributing to death bu | t not resulting in the ur | nderlying cause give | n in Part I. | 23e. Did toba | acco use contribu | te to the cause of death? |
| ord | w requir been si should I | | 11 | iension | | | | 1 🗆 Yes | : 2 □ No 3[| Probably 4 dtnknown |
| ec | e law has b | Completed | HY pol | hyroid | 15 m | | | 24a. Was an autopsy | prior | e autopsy findings available |
| al F | | | | | | | | | 10 | Yes 2₽No |
| Ϋ́ | | o Be | 25. Was case referred to medical examiner? | lospital: | nt 2 ☐ ER/Outpatien | Othe | 26. Place of Death | | | 2 |
| of | ding Phys h. After this funeral di | n: To | 27. Manner of Death | 28a. Date of Injury | 28b. Time of | 28c. Injury | at a | ne 5 ☐ Resider 28d. Describe hov | | Specify) |
| ion | Attending r death. ector: After by the fune | atlo | 1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) Injury | Work M 1 □ Y | es 2 □No | | | |
| Division of Vital Records, | l or Attendation after deati | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Inju building, etc. | ry - At home, farm, stre (Specify) | eet, factory, office | 1 | 28f. Location (Stre City or Town, | et and Number of State) | or Rural Route Number, |
| | Hospital or 24 hours afte Funeral Dir tely filled in | | 29a. Certifier 1 Certifying Phy | ricine. To the best of | 6 m. J | | | | | |
| | To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the | edical | (Check only 2 Medical Exami | ner: On the basis of and manner stat | f my knowledge, death examination and/or inv ed. | estigation, in my op | e, date and place, a inion, death occurre | ed at the time, dat | e and place, and | or as stated. due to the cause(s) |
| | within To th | Me | 29b. Signature and title of certifier | | | 29c. License | | 29 | d. Date signed (A | fonth, Day, Year) |
| | | | I thank of | nmn | | 1 23 | 35102 | m | Arch 2 | 23 2009 |
| | | | 30. Name and address of person who co | - | ath (Item 23a) (Type, | Print) | 11 7 | | | 11000 |
| | Sta | to | 31. Date filed (Month, Day, Year) | | | o th 91r | vel PA | itimior (| e man | YLAND |
| | Sta | ar i | MAR 2 4 2009 | 12. | r's Signature | Kal | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 53 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2:14 PM **Physician** Jay Emory Cook /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Anne Arundel Co. Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Min Months 1928 Maryland Feb. 16, 217-22-5224 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County ral", or items 23a or 28a-f show Examinar must be notified at 1 ☐ Yes 2 No Director Glen Burnie Maryland Anne Arundel Co. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 United States 203 9th Avenue, SE Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ρ Specify. 3 Widowed 4 Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) d other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other than "r traumatic even?" Elementary/Secondary (0-12) College (1-4or 5+) Field Engineer 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thawley Anna Mae Paul E. Cook ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21061 203 9th Avenue, SE Glen Burnie, MD of Health Mrs. Betty Cook / Wife Department of Health Important: If item 27 any Injury or other troope. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 03/27/2009 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Singleton Funeral & Cremation Services; 1 2nd Ave. SW Glen Burnie, MD 21061 M01121 Approximate Interval Between Anset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. we how Immediate Cause (Final Physician SO min disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a convequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 probably 4 Unknown 1 ☐ Yes 2 ☐ No icate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔼 2 N 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 🔲 Inpatient 2 DFF/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

E Funeral Director: A pletely filled in by the fu death. 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and mamper stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Div

State

31. Date filed (Month,

Registrar

DHMH 17 Rev 1/2001

Deserva B. 40

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2 4 2009

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| | | | For State Registrar | State o | of Marylan | | artment | | | and M | • | • | 2000 | | 1 |
|------------|--|----------------|---|---|--|-------------------------------------|------------------------------------|----------------------|----------------------------|-------------------------|--|--------------------------|--------------------------------|--|----------------------|
| ı | Physici | an | Decedent's Name (First, Middle Naomi Holt Ct | | | | | | | | 2. Date of De Month | Day | Year | 3. Time of | |
| | /Medic | | 4a. Facility Name (If not institution | | mber) | | 4b. City. | Town. or | Location of | of Death | March | 18 4c. 0 | 2009 County of Dea | | A |
| | Examir | ier | 6645 Fairfax | | | | | | Chase | | | | ontgom | | |
| Ī | Funeral Director | | 5. Social Security Number 213-38-4679 | 6. Sex 1 ☐ M 2 🛣 F | 7. Age (<i>In yrs</i> . 97 | <i>last birthday)</i> Yrs. | If Under Months | | If Under: | | 8. Date of Bir (Month, Da November | th year) 27, 19 | 9. Bir Co 911 Was | thplace (State country) | |
| | yland Iow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | | 10d. Inside Ci | |
| | the Man | Director | Maryland Mont | gomery | Ch | evy Ch | ase | Codo | | | | 10a Citia | en of What Co | 1 □Yes | 2 X No |
| | with la or | | 6645 Fairfax | Pood | | | | 815 | | | | | ited S | | |
| | ms 2; | Funeral | 11. Marital Status | 12. Was Dec | edent Ever in U. | S. 13. | | | spanic Ori | igin? (Spe | ecify Yes or No Rican, etc.) | | 4. Race - Ame | erican Indian, | |
| 220 | be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Medical Evanther must be notified at | þ | 1 ☐ Never Married 2 ☐ Mai 3 🎇 Widowed 4 ☐ Divorced | If Yes, Gi | 2 ∑]No ive | | if Yes, spec 1 □ Yes 2 | | Specify: | | Rican, etc.) | - | Black, White Specify: | e, etc. hite | |
| 215-0036 | 72 hou | eted | 15. Decede | nt's Education est grade completed) | | 16a. Dece | dent's Usua | l Occupa k done d | ation | t of worki | na | 16b. Kin | d of Business | | |
| 171 | within iene. than " | Completed | Elementary/Secondary (0-12) | College (| 1-4or 5+) | | kind of word DO NOT us tist | e retired, | , , | | | S | elf-Em | ploved | |
| פַ | al Hyg other vent, | BeC | 17. Father's Name (First, Middle | Last) | | | | | 18. Mothe | er's Name | (First, Middle, | | | | |
| yland | should be and Mental s marked o umatic eve | 2 | Fred Holt | | | , | | | Bla | anche | Naomi | Thom | pson | | |
| <u>=</u> | es 1 and 2 should be of Health and Mental item 27 is marked or other traumatic ever | | 19a. Informant's Name/Relation: Bever1y Y. Ca | | Ο Λ | | _ | | | | al Route Numb | | | | |
| e, | tem 2 | 1 | 20a. Method of Disposition | marrer/r. | | Place of Dispo | | | - 1 | D | Date | | ation - City or | d 20815 Town, State | |
| Ē | Pages nent of int: If i | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$ | | State | ^{semetery, crei} k Cree | | | i 1 | Marc 20 | h 25, | Wash | nington | D.C. | |
| pallimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. | | 21. Signature of Funeral Service | dicensee At | M01546 | Ŕ | Name and | d Addres | s of Facilit | Fune: | ral Home, Bethesda | /Bethe | sda-Chev | y Chase, | Inc. |
| | Physician | 8 0 | 23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final | t only one cause on e | caused the deat | h. Do not ent | ter the mode | e of dying | g, such as | | | | | Approximate Interval Bette Onset and I Years | ween |
| | /Medical Examiner | | disease or condition resulting in death) | a | (or as a conseq | | neart | D18 | case | | | | - | Teals | |
| | ed sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to | (or as a conseq | uence of): | | | | | _ | | | | |
| Ď, | cate be executed only sician and the burial-transit | I Examiner | that initiated events resulting in death) Last | c | (or as a conseq | uence of): | | | <u>.</u> | | | | | | |
| 00/00, | icate t physic | dical | | d | | | | | | | | | | | |
| O. DOX | ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown | 1 Live | tcome of pregna birth 2 Peta mant at time of c | Ideath 3 | ⊒Ectopic pr ⊒Other <i>(sp</i> e | | , | | | 2 | 3d. Date of de Month | | Year |
| , 7. | s that the | by Phy | Part II. Other significant condit | _ | | - | | use give | n in Part I. | | 23e. Did t | obacco us | se contribute to | the cause of d | leath? |
| ecoras, | require een sig oould b | | Cerebrovascula | r Acciden | t, Hype | rtensi | on | | | | 1 🗆 ' | Yes 2□ |]No 3□ P | robably 4 🕅 l | Jnknown |
| e e | Physician: The law rithis certificate has braid director, page 2 straid director, page 3 straid director, page 3 straid director, page 3 straid director, page 3 straid director, page 4 straid director, page 4 straid director, page 5 straid director, page 6 straid direct | Completed | | | | | | | - | | 24a. Was autop perfo 1 Yes | osy rmed? | prior to death? | utopsy findings completion of c | available ause of |
| VII.a | slcian certif rector | Be | 25. Was case referred to medica examiner? 1 ☐ Yes 2 🖔 No | Hospitals | | | | Othe | r. | | (Check only o | | | | |
| | g Phy er this eral d | n: To | 27. Manner of Death | | Inpatient 2 of Injury oth, Day, Year) | 28b. Time o | | A Bc. Injury | 4 ⊔ Nu at | | me 5 📉 Resi 28d. Describe l | | | ecify) | |
| | Attending or death. ector: After by the funer | atio | E | igation | ıın, Day, Year) | Injury | М | Work 1 □ \ | ? /es 2 □ 1 | No | | | | | |
| DIVISION | ial or Atte | Certification: | 3 | not be nined 28e. Place build | e of Injury - At he ing, etc. (Specit | ome, farm, str fy) | eet, factory, | office | | 1 | 28f. Location (; City or To | Street and vn, State) | Number or R | ural Route Num | ber, |
| (3) | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical (| 29a. Certifier 1 X Certifyi (Check only 2 Medica one) 1 Medica | ng Physician: To the Examiner: On the b and mar | e best of my kno basis of examina nner stated. | owledge, deat ation and/or in | h occurred avestigation, | at the tin | ne, date ar pinion, dea | nd place, ath occurr | and due to the red at the time, | cause(s) date and | and manner a place, and due | s stated. e to the cause(s | i) |
| | To tl withi To tl | ž | 29b. Signature and title of certific | ir | | | 29c. | . License | number | | | 29d. Date | signed (Mont | h, Day, Year) | |
| | | | | | | m | 1 | D33 | 357 | | | Ma | rch 20 | , 2009 | |
| | | | 30. Name and address of person Lee Jonathan A | | | | | n Av | enne | #10 | 45. Ch | evv C | hase. M | Maryland 2 | 20815 |
| | Sta | ite | 31. Date filed (Month, Day, Year, | 3 9 F | Registrar's Signa | | sel) | | | | .5, 011 | | | | |
| | Registr | ar | MAPRA | 2000 /2 | and a B | 1 1900 | Ser | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per FH g889 3/2/09 IT

| | 1 | State of Maryland / Departn | cate of Death | | grene Reg. No. 2000 00150 |
|--|------------------|--|--|------------------------------|--|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | 2. Date of Dea | ath 3. Time of Death |
| Physicia | _ | IRENE CARRINGTON | | Month MARCH | Day Year 2009 3:15 A M |
| /Medic | | | City, Town, or Location of Dear | | 4c. County of Death |
| Examin | 31 | | BOWIE | | PRINCE GEORGE'S |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If C | Inder 1 Year If Under 24 Hrs | | h 9. Birthplace (State or Foreign Country) |
| Director | | 230-10-8947 1□ M 2፟M F 88 Yrs. Mo | nuio Bays House IIIII | JAN. 11 | , 1921 VA |
| pu > | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | n | | 10d. Inside City Limits |
| aryla sho | | Total States | | | 1 □Yes 2 🕅 No |
| the M | ec j | MD PRINCE GEORGE'S UPPER MARL | BUKU of, Zip Code | | 10g. Citizen of What Country? |
| with t | <u>ā</u> | 2712 MATAPEAKE DRIVE | 20774 | | USA |
| ns 23 | Funeral Director | | Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer | Specify Yes or No- | |
| ING 21215-UU30 be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or items 23a or 28a-f show event, it a Marical Eraminar must be recilled at | | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Y | s, specify Cuban, Mexican, Puel ′es 2⊠No <i>Sp</i> ec <i>ify:</i> | to Hican, etc.) | |
| Z15-UU36 hin 72 hours aft e. an "natural", or Model Erani | d by | 3 X Widowed 4 □ Divorced Year or Dates: | s Usual Occupation | | BLACK 16b. Kind of Business/Industry |
| n 72 "nat | olete | (Specify only highest grade completed) (Give kind | of work done during most of wo IOT use retired) | rking | , |
| d 2121 filed within Hygiene. other than " ent, it e Me | Completed | Elementary/Secondary (0-12) College (1-4or 5+) 12TH SEAMST | RESS | | TEXTILE |
| aryland 2 should be filed v ind Mental Hygie marked other t umatic event, II | Be C | 17. Father's Name (First, Middle, Last) | 18. Mother's Na | me (First, Middle, | Maiden Surname) |
| yland yland ould be file Mental Hi larked oth | To B | ABRAM WALKER | | ROBERTS | |
| Maryla Id 2 should I Ith and Men 27 is marke 1 traumatic | | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ac | ldress (Street and Number or F | ural Route Numbe | er, City or Town, State, Zip Code) |
| | | | ATAPEAKE DRIVE | | MARLBORO, MD 20774 |
| 0 0 | | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition SALEM BAP II | N (Name of CHURCH | Date | 20c. Location - City or Town, State |
| timore it. Pages 1 rtment of H rtant: If ite | | 4 □ Donation 5 □ Other (Specify) CEMETERY | 03-2 | 8-2009 | RED OAK, VA |
| Baltimo permit. Pag Department Important: I any injury conce. | | 21. Signature of Funeral Service Licentee 22. Na 22. Na 22. Na 22. Na | 4308 SUITLANI | | S FUNERAL HOME OF MD SUITLAND, MD 20746 |
| | | 23a. Parf1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. | e mode of dying, such as cardi | ac or respiratory a | Interval Detween |
| Physician | 8 6 | Immediate Cause (Final disease or condition ADVANCED DEMENTIA | | | Onset and Death YRS. |
| /Medical | | resulting in death) Due to (or as a consequence of): | | | |
| Examiner | _ | Sequentially list conditions, b. | | | |
| ted | niner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | |
| sxecur n and al-trar | Examin | that initiated events c | | | |
| 68760, ificate be executed g physician and ss the burial-transit | dical | d | | | |
| | | To service | | | |
| Geath certific death certific e attending p | an/ | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ec | topic pregnancy | | 23d. Date of delivery Month Day Year |
| . 0 00 | Physician/M | 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Otl | ner (specify) | | , worth |
| <u> </u> | | Part II. Other significant conditions contributing to death but not resulting in the under | lying cause given in Part I. | 23e. Did t | obacco use contribute to the cause of death? |
| Records, P.O he law requires that the e has been signed by th | d by | | | 1 🗆 ' | Yes 2ሺ No 3 Probably 4 Unknown |
| cord w requir s been si should I | lete | | | 24a. Was | an 24b. Were autopsy findings available |
| ~ C D | Completed | | | | psy prior to completion of cause of death? |
| | a) | 25. Was case referred to medical | 26. Place of D | 1 □Yes eath (Check only o | |
| of Vita Physician: rthis certific | 0 13 | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 | Other: | | dence 6 Other (Specify) |
| Division of Vital I or Attending Physician: 1 after death. Director: After this certifical din by the funeral director, p | on: T | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe | how injury occurred |
| SiO tendi leath. lor: A the fu | cati | 2 Accident investigation | M 1 Yes 2 No | 29f Location / | Street and Number or Rural Route Number, |
| Divisic | Certification: | 3 Suicide 6 Could flot be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify) | factory, office | City or To | |
| urs urs ille | | 29a. Certifier (Check only (Check only 2 Medical Examiner) On the basis of examination and/or invest | curred at the time, date and pla | ce, and due to the | e cause(s) and manner as stated. |
| To the Hosp within 24 ho To the Fune completely f | Medical | one) and manner stated. | | | 29d. Date signed (Month, Day, Year) |
| with voint | 2 | 29b. Signature and title of certifler | 29c. License number | | |
| | | MIS. | D41978 | | MARCH 23, 2009 |
| | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin | 22.5 GLENDALE, | MD 2076 | 69 |
| Sta | te. | NADER TAVAKOLI 12200 ANNAPOLIS ROAD # 31. Date filed (Month, Day, Year) NAR 2 4 2009 | GLENDALE, | 20/۱ کنت | |
| Registi | | MAR 2 4 2009 Kengan 1. | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Richard 1225 P.M Davis Arlen 03 2009 /Medical 49 City, Town, or Location of Death BALL MURE 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner timure VA MediCALCENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: if item 2.3a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinst must be notified at 1 res 2 No BAltimore Funeral Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number East EAGER STreet 21205 Was Decedent Ever in U.S.
Armed Forces?
1 1 res 2 No Army
If Yes, Give
Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Gold Bond LABORCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ILLIAM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5046 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Important: If any injury or once. March 24, 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. ZAWIND Jr. 21. Signature of Funeral S St-Balto. ONK/ING r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the disc ase, shock, of heart fail re. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** elevation Intarction Myocardial disease or condition (resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIOMY Opathy, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2-No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day,

Kimberly Boswellauc

Boswell

MAP24

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

Marken Mar

29c. License number

29d. Date signed (Month, Day, Year)

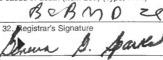
ION GREENC STREET BALLIMIRE, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 9 Day Month 6 120 M **Physician** March 20 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Canton Harbor Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8 – 8 – 1 9 3 7 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 □XF 71 MD Director 236-62-6040 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 □Xes 2 □ No Director Baltimore City MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21224 USA or items 23a 455 Hornel Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ð Specify: White 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) White Coffee Pot 12 Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Laura R. Davis George E. Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 455 Hornel Street, Baltimore, MD 21224 Teresa Slater - Daughter Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 3-24-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bradley-Ashton FuneralHome 2134 Willow Spring Road, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hero se disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, physician death certificate be Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 mor Month Year Day 5 Other (specify) signed by the a o 9 Unknown <u>a</u>: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has this certificate 1 ☐Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? al or Attending F after death. I Director: After After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Hospital of 24 hours at B Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 1 within 2 To the 1 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

MAD 2.4.2009



person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH \$300 4/06/09 JH State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year March 21 2009 11:17 PM homa avies /Medical 4a. Facility Name (If not institution, give street and number) 4b. Gify, Town, or Location of Death 4c. County of Death **Examiner** lodiCAL Ltimore more . Social Security Number 212 - 02 - 0289 f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 7 - 2 - 1 9. Birthplace (State or Foreign Country)
Maryland **Funeral** Months 1**X** M 2□ F Days Hours Min Yrs. -2-1926 82 Director Usual Residence of Decedent 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examination in the invitited at 10c. City. Town or Location 10d. Inside City Limits Director 1 XI Yes 2 □ No N/A MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 529 South Lakewood Avenue 21224 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 N/A Salesman Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Davies Elizabeth Morgan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 4 19a. Informant's Name/Relationship (Type. Print) 529 South Lakewood Avenue Baltimore, MD Dorothy K. Davies (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-26-09 Holy Rosary Cem. Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA Tools B 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** SCHEMIC CARDIDMY OPATH disease or condition resulting in death) / YEAK C /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trans resulting in death) Last Due to (or as a consequence of) physician Physician/Medical use as t attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy p in the past 12 months? Month Day Year 5 ☐ Other (specify) led by the g detached f 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YULMONATY DISEALE OBSTRUCTUE 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 🔽 director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient After this c 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, 27. Manner of Death 1 Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Year) 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Aft completely filled in by the fun 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. infer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical 29b. Signature and ti of cert 29c. License numbe 29d. Date signed (Month, Day, Year) MD

Registrar
DHMH 17 Rev 1/2001

State

MICHAEL

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

10N

2. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD, PhD

KESTI

MAR 2 4 2009

| | | | For State Registrar | State o | f Marylar | | artment of rtificate o | | | lental Hy | ygien Reg. No | 200 | 9 1916 | |
|---------------------|--|-----------------|--|---|--|----------------------------------|--|---------------------------------------|---------------------------|---------------------------------------|------------------------|---|--|--|
| | Dhusis | | 1. Decedent's Name (First, Mid | dle, Last) | | | | | | 2. Date of D | eath | | 3. Time of Death | |
| 1 | Physic /Medi | | Frankie | Mae | | edge | | | | Month 03 | 2 0 | 2009 | 01:42 p ^M | |
| | Exami | ner | 4a. Facility Name (If not instituti Good Samaritan Nu | | | | 4b. City, Town, Baltimore | | of Death | | | . County of De | ath | |
| | Funeral Director | | 5. Social Security Number 461-34-1664 | 6. Sex 1 □ M 2 🙀 F | 7. Age (In yrs. 82 | last birthday) Yrs. | If Under 1 Yea Months Day | Year If Under 24 Hrs. Days Hours Min. | | 8. Date of Bi (Month, D 06/07/1 | | • | irthplace (State or Foreign Country) | |
| | and | | Usual Residence of Decedent 10a. State 10b. Count | v | 10c Ci | ty, Town or Lo | cation | - | | | | | 10d. Inside City Limits | |
| | Maryli f sho | to | Texas Hopkin | | Pick | | Cation | | | | | | 1 ☐ Yes 2 🔀 No | |
| | h the | Director | 10e. Street and Number | | 110 | COL | 10f. Zip Code | | - | | 10g. Ci | tizen of What 0 | Country? | |
| | 23a c | ral | Rt. 1 Box 122 | | | | 75471 | | | | U. S | 5. A. | | |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Mardical Everning. But the natified at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 ☑ Ma 3 ☑ Widowed 4 □ Divorce | rried Armed Fo | ² ₩No ve | | Was Decedent of If Yes, specify Cu 1 □Yes 2☑No | ban, Mexica | n, Puerto | ecify Yes or N Rican, etc.) | 0- | 14. Race - An Black, Wh Specify: Wh | ite, etc. | |
| 2-0 | 72 hou natura | eted | 15. Decede | nt's Education est grade completed) | | 16a. Dece | dent's Usual Occ | upation | at of model | | 16b. K | (ind of Busines | | |
| 21215-0036 | d within giene. er than " | Completed | Elementary/Secondary (0-12) | College (1 | -4or 5+) | | kind of work don DO NOT use retii Maker | e dunng mos red) | st of Worki | ng | 0 | Own Home | | |
| Baltimore, Maryland | uld be file Mental Hy rked othe | To Be (| 17. Father's Name (First, Middle Ollie Hart | , Last) | | - | | | er's Name | (First, Middle | , Maider | Surname) | | |
| lary | 2 shours and It is ma | - | 19a. Informant's Name/Relation | | | 19b. Mailir | ng Address (Stree | et and Numb | er or Rura | al Route Numb | er, City | or Town, State, | Zip Code) | |
| e, | 1 and Health em 27 ther tr | | Ellene Whitworth, | Daughter | lan s | | sley Cour | | | | | | | |
| nor | Pages nent of than to the sant: If ite | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation | | | | sition (Name of natory or other pl | | | ate (0000 | | ocation - City o | | |
| altin | permit, P Departme Importan any injury | 1 | 4 ☐ Donation 5 ☐ Other (| | MIII | | Cemetery . Name and Add | | 03/26/ by Lea | onard J. | | kton, Tex , Inc. | as | |
| | 20 E # 9 | 0 | Olefand | | in_ | | 305 Harfor | | · | timore, 1 | | 214 | | |
| 58760, ¢ | Physician /Medical Examiner bulkisician and physician and the prival-transit the prival-transit | edical Examiner | 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and least of the cause. The Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (| or as a consequence or a consequence or a consequence or a consequ | uence of): | Sladde | | | | arrest, | | Approximate Interval Between Onset and Death | |
| P.O. Box 687 | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknovn | 4 ☐ Pregr 9 ☐ Unkn | oirth 2□Fetal nant at time of d own | I death 3 🗆 leath 5 🗆 | Ectopic pregnar | | | | | 23d. Date of do Month | Blivery Day Year | |
| rds, | w requires that been signed should be de | þ | Part II. Other significant condit | ons contributing to de | ath but not resu | liting in the un | | Pen in Part I | کر | 23e. Did t | 1 | ſ | o the cause of death? Probably 4 Unknown | |
| tal Record | sician: The law re certificate has be rector, page 2 sho | Completed | OF Was seen referred to the state of the sta | | | | | | | 24a. Was autoj perfo 1 🗆 Yes | | prior to death? | utopsy findings available completion of cause of | |
| Vital | ysicia s certi | o Be | 25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ W | Hospital: | npatient 2 | EB/Outpation | Ot Ot | | | (Check only o | | | | |
| 0 | ng Ph fter thi | $\vdash v$ | 27. Manner of Death Natural 5 ☐ Pendin | 28a. Date of | | 28b. Time of Injury | 28c. Inju | ırv at 🔪 | | 8d. Describe | | 6 ☐ Other (Spery occurred | ecity) | |
| SIO | tendil leath. tor: A the fu | catio | 2 Accident investi | gation | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,, | | Yes 2□ | No | | | | | |
| Division of | al or At after c I Direc d in by | Certification: | 4 Homicide determ | ained 28e. Place | of Injury - At ho ng, etc. <i>(Specif</i> y | me, farm, stre | et, factory, office | | 2 | 8f. Location () City or To | Street an vn, State | d Number or R) | ural Route Number, | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, pompletely filled in by the funeral director, possible the property of the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director, possible the funeral director of the f | edical C | 29a, Certifler (Check only one) | ng Physician: To the Examiner: On the ba and mann | isis of examinat | wledge, death tion and/or inv | occurred at the restigation, in my | ime, date ar opinion, dea | nd place, a th occurre | and due to the ed at the time, | cause(s date and |) and manner a d place, and du | s stated. e to the cause(s) | |
| | To th withir To th comp | Me | 29b. Signature and title of certified | Thorn | \bigcirc | | 29c. Licen | se number | 7 N | 4 | 29d. Da | te signed/(Mon | th, Day, Year) | |
| • | | | 30. Mamerand address of person | who completed cause | e of death (Item | 23a) (Type, F | Print) Rospin | RIU | 1 | Ro H | · Mar | mi | 71779 | |
| į | Sta Registra | ~ | 31. Date filed (Month, Day, Year) | 09 Jane | egistrar's Signat | fare | Raven | 5,00 | | | 77207 | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** EARLE **EISENBERG** LEONARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTI BAZTIMONE MORG N/A MOSPITM OF If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2□ F Months Days Hours MD 216-16-9310 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Mydical Examiner must be notified at once. 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 7 SLADE AVENUE, #603 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🛣 No Specify. ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWNER MANUFACTURING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **EISENBERG** BESSIE BENESCH ၉ HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SLADE AVENUE, #603, BALTIMORE, MD ELAINE EISENBERG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH 03/22/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer ngeal **Physician** ary disease or condition resulting in death) /Medical Due to (nas a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 3 robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe (es 2 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Attending Physician: The law requires that the death certificate be executed ুত Division of Vital Records, P.O. Box 68760,

しょとんる そりろ , Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 2 4 2009

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

62254 MARCH, 20,2009

TIWICA, 2401 W BRIVEDENE AVE, BALTIMORE, MD 30. Name and address of person who comple

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No:-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1910 PM Ò SAM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner N/A BALTMORE 9 MD MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**√** M 2□ F Jan 5, 1947 So. Carolina Director 215-46-5535 62 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location ¥□Yes 2□No ral", or items 23a or 28a-f sh Examiner must be notified Baltimore Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 21230 1158 Nanticoke Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 1969 Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥☐ No Specify. þ Rlack 3 ☐ Widowed 4 ☐ Divorced "natural" 1969 er than "natura", the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **MTA Bus Driver** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 7 is marked c traumatic eve Pearlie Johnson Sam Epps Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 1158 Nanticoke Street Baltimore, Maryland 21230 Ida Myers Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/20/09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTILEMIA /Medical Due to (or as a consequence of): **Examiner** PAN - COLITIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sician Physician/Medical phys the E 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ CELL 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number NF1 1104085448 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 12,2009 19005 umac 30. Name and address of person who completed sise of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

M

UNIV

Registrar's Signature

THOMAS

MAR 2 4 2009

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** FIRMAN M DAVID 2009 MARCH 14. 3:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE Trunder 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JULY 25, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 OLLTO **Funeral** 1**√** M 2□ F 93 OHIO 563-09-2463 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No **Funeral Director** BALTIMORE LUTHERVILLE 10e. Street and Number 10g. Citizen of What Country? 21093 USA 113 ARDOON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: þ WHITE 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) GEOGRAPHIC/ Elementary/Secondary (0-12) College (1-4or 5+) ENVIRONMENTAL PLANNING **PROFESSOR** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FIRMAN BILOBORODOV ပ SAMUEL IDA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3930 WOODROW ST.; ELLICOTT CITY, MD 21043 JEFFREY FIRMAN / SON 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM.GDNS 3/23/2009 TIMONIUM, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** caus /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No <u>Р</u> О 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by aho ce tic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe yes 2 1 ☐ Yes 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed_(Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month Day A^{M} 21, Mary Joseph Giovanis March 2009 06:50 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore City 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) Year) Months Days Hours 1 □ M 2 🕅 F 216-09-0624 Sept. 96 1912 15, Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 Chelsey Ave. 21234 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify. Specify: White 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William List Lillie Pleasant List 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 130 Highland, Maryland 20777 Theodore Giovanis, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland Moreland Mem. Park 3/24/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature/of Funeral Service Licenses Evans Funeral Chapel & Cremation Services - Parkville 23a. Part1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8800 Harford Road, Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro vascular disease or condition resulting in death) month Due to (or as a consequence of): Atherescieratio Credic vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Vementio 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **X** No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending

/Medical Examiner certificate be executed and Box 68760, P.0. the Division of Vital Records. aw i has The certificate To the Hospital or Attending Physician: this After ours after death.

neral Director: Af
filled in by the fur within 24 hours a

Examine burial-trar physician at the burial Physician/Medical attending properties for use as detached signed by t ð Completed page 2 director, Be Certification: To funeral Medical

Physician

/Medical

Examiner

Funeral

Director

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al Hygiene.

and Mental and 2 should be Is marked

Item 27 I

permit. Pages 1
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Important: If Iten
any Injury or oth

Physician

Baltimore, Maryland 21215-0036

or than "natural", or items 23a or 28a-f sho

Director

Funeral

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Completed

Be

| 2 Accident | М | 1 □Ye | s 2 □No | | | | | | | |
|-----------------------------|------------------------------|---|----------------------|--------------|--------|---|--|------|--|--|
| 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | | | | | | | e cause(s) and manner as stated. e, date and place, and due to the cause(s |) | | |
| 29b. Signature and titl | e of certifier | | | 29c. License | number | | 29d. Date signed (Month, Day, Year) | | | |
| · Cope | ulene les | 1 | | Da | 8787 | | 3/21/2009 | | | |
| 30. Name and address | s of pers o n who con | pleted cause of death (Item | n 23a) (Type, Print) | | | | • | | | |
| 31. Date filed (Month, | perling, Day, Year) | 32. Regiétrar's Signa | 5001. | Lach | Paven | Blvd | . Ballimore, MD | 2123 | | |
| | MAR 2 4 2 | 309 Denewa | B. pa | New | | | | | | |

State Registrar

| | 1 | For State Registrar | State of | i waryian | id / Depa <i>Cei</i> | | | eaith an Death | ia ivie | | eg. No. | / | 0916 |
|--|-------|---|---|--|----------------------------------|----------------------------------|----------------------|---|-----------------------|--|---|--|---|
| ysician | 1 | . Decedent's Name (First, Middl ELEANOR | | | GROSS | | | | | Date of Deat Month arch | h Day | Year 2009 | 3. Time of Death 4:10 p |
| ledical aminer | 4 | a. Facility Name (If not institution | | nber) | CINODE | 4b. City | , Town, or | Location of D | | <u></u> | | County of Death | |
| | 5 | 3723 REISTERS Social Security Number | | 7. Age (In yrs. | last hirthday) | | ALTIM er 1 Year | ORE If Under 24 | Hrs. I a | Date of Birth | | N/A | place (State or Foreign |
| al or | | 217-24-4440 | 1 □ M 2 XX | | 80 Yrs. | Months | | | Min. | Date of Birth (Month, Day, Oct. 19 | <i>Year)</i> 192 | | place (State or Foreig intry) YLAND |
| | _ | Usual Residence of Decedent Oa. State 10b. County | | 10c Cit | ty, Town or Lo | cation | 1 | | | | | | 10d. Inside City Limits |
| ō | | | | 100.01 | , | | - | | | | | | XXYes 2 □ No |
| Director | 1 | MARYLAND N/ 0e. Street and Number | <u>A</u> | | B. | ALTIN 10f. Zi | MORE p Code | | | 1 | 0g. Citiz | zen of What Cou | ntry? |
| a D | | 3723 REISTERS | TOWN RD. | | | | 21 | 215 | | | Ū | J.S.A. | |
| by Funeral | 1 | Marital Status Never Married 2 ☐ Mar Widowed 4 ☐ Divorced | Armed Fo | /e | | Was Dece f Yes, spe l □Yes | | ispanic Origin n, Mexican, P Specify: | ? (Speci uerto Ric | fy Yes or No- can, etc.) | | 4. Race - Ameri Black, White, Specify: BLA | etc. |
| ied E | ŀ | 15. Deceder | t's Education | 4103. | 16a. Dece | dent's Usi | ual Occupa | ation | l warkina | | 16b. Kir | nd of Business/Ir | |
| Completed | 1 | Elementary/Secondary (0-12) | st grade completed) College (1 | -4or 5+) | life, i | DO NOT i | use retired | furing most of) | working | 117 | | | |
| CO | - | 12th grade 7. Father's Name (First, Middle, | l ast) | | NURS | ES A | ID | 18. Mother's | Name (f | First, Middle, N | | NTAL CAR | E |
| To Be | | EDWARD DICKEY | Lasty | | | | | | · | BAKER | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ourname, | |
| ř | | 19a. Informant's Name/Relations | hip (Type. Print) | | 19b. Mailir | ng Addres | s (Street a | | | | r, City or | Town, State, Zi | ip Code) |
| | | Brenda L. Smit | h/Daughte | <u> </u> | 161 | 9 St. | . Pau | 1 St., | Balt | | | yland 2 | |
| | 2 | 20a. Method of Disposition 1 Burial 2 □ Cremation | 3 Removal from | | Place of Dispo cemetery, crer | sition (Na natory or | ame of other plac | e) | Dat | е | 20c. Lo | cation - City or To | own, State |
| | L | 4 Donation 5 Other (S | | WO | ODLAWN | | | 03 | -25- | 09 | WOOD | LAWN, M | ARYLAND |
| | 1 | 21. Signature of Funeral Service | Licensee | _ | W | ILLIA | AM C | BROWN TH AVE | | UNITY | FUNE | CRAL HOM | E P.A. |
| Examiner | 1 | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last | a. Sm Due to (b. Due to (| ach line. AN Ce for as a consequence of the conse | uence of): | 9 (| anc | icr | | | | | Interval Between Onset and Death II Mon-His |
| III STORING TO STORING | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 No 9 ∐Unknown | 1 ☐ Live I 4 ☐ Pregi 9 ☐ Unkn | | al death 3 E death 5 E | Other (s | | | | | | 23d. Date of delive | Day Year |
| by | ١. | Part II. Other significant conditi | ons contributing to de | eath but not res | sulting in the u | nderlying | cause give | en in Part I. | | | bacco u: es 2[| | the cause of death? |
| Completed | /d, - | | | | | | | | _ | 24a. Was a autops perfori | n | 24b. Were aut | opsy findings available ompletion of cause of |
| Be C | | 25. Was case referred to medica examiner? | | | | | | | Death (| Check only on | | 100 | 2 |
| | | 1 ☐ Yes 2 🗙 No | | Inpatient 2 | | | | 4 LI Nursi | | | | Other (Spec | ify) |
| ion: | 2 | 27. Manner of Death 1 X Natural 5 ☐ Pendir 2 ☐ Accident investi | | of Injury th, Day, Year) | 28b. Time of Injury | м | 28c. Injur | yat (? Yes 2∐No | | d. Describe ho | ow injury | occurred | |
| Certification: To | | 2 Accident Investi 3 Suicide 6 Could 4 Homicide detern | not ho | of Injury - At h ng, etc. <i>(Speci</i> | ome, farm, str | | | | | f. Location (Si City or Town | treet and n, State) | d Number or Run | ral Route Number, |
| Medical | | | ng Physician: To the Examiner: On the band man | | | | | | | | | | |
| Me | | 29b. Signature and title of certifie | | | | 29 | 9c. Licens | e number | | 2 | 9d. Date | e signed (Month) | , Day, Year) |
| | | Churai | - Har | | | | DE | 0372 | | | Ma | 17ch, 24 | t, 2009 |
| | 3 | 30. Name and address of person | ears st | CRB | 2. RV | n 5 | 53, | Bait | 1Me | rc, M | D | 21231 | |
| | | | | legistrar's Signa | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year 7:00 P M Frank C. Gigliotti, Sr. 2009 20 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 1 Stag Court
5. Social Security Number Phoenix If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√** M 2□ F Months Days Director 218-44-3121 64 Mary land May 28. 1944 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov 1 □Yes 2√□No Director Phoenix Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21131 1 Stag Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene.
Important: If item 27 is marked any injury or other. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√☐ No þ Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Hornfeck မ Joseph Gigliotti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Laima Gigliotti/ Wife Phoenix, Md. 21131 1 Stag Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-26-09 <u>Garriso</u>n Forest Va. Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1451101112 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery regnancy Month Day Year ecify) signed by the ð

nis certificate has been s director, page 2 should eral Director: After th filled in by the funeral

Completed

æ

Certification:

Medical

| in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 | 3 ☐ Ectopic pr 5 ☐ Other (spe |
|---|--|----------------------------------|
| art II. Other significant conditions | contributing to death but not resulting in t | the underlying ca |

ause given in Part I 23e. Did tobacco use contribute to the cause of deal? 1 ☐ Yes 2 No 3 Probably

| | | | | ·- | | 24a. Was an autopsy performed? 1 □ Yes 2 1 No | 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No |
|---|---|------------------------|-----------------------------------|------------------------------------|---------------------------------|--|--|
| 25. Was case referred to medical | | | | 26. P | lace of Death | (Check only one) | |
| examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ |] ER/Outpatient | me 5 Hesidence 6 □Other (Specify) | | | | |
| 27. Mann, of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati | 28a. Date of Injury (Month, Day, Year) on | 28b. Time of Injury | 280 M | c. Injury at Work? 1 ☐ Yes 2 | 1 | 8d. Describe how injury | occurred / |
| 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | | ome, farm, street, | factory, c | office | d Number or Rural Route Number, | | |

| 29a. Certifier | 1 Certifying | Physician: To the best | f my knowledge, death occurred at the time, date and place | and due to the cause(s) and manner as stated. |
|-------------------|-----------------------|--------------------------|---|---|
| (Check only | /2□ Medical Ex | caminer: On the bases of | examination and/or investigation, in my opinion, death occu | rred at the time, date and place, and due to the cause(s) |
| one) | h. | and mariner sta | ted. | |
| 29b. Signature ar | nd title of certifier | ///// | 29¢ License number | 29d Date signed (Menth Day Year) |

| 1,100 | 1)0030149 | 0/40 |
|--|-----------|--------|
| 30. Name and address of person who completed cause of death (Item 23a) (Type | TOUSON MA | 212076 |

State Registrar 31. Date filed (Month, Day

Registrar's Sign

24 hours a

| | | • | 1 - For State Registrar amend 6 per | State of Marylan | | | | - | giene 0 0 | 9 09167 |
|----------------------------|--|---------------------------|---|---|------------------------|--------------------------------------|------------------|--|-----------------------------------|---|
| | Physici | an. | 1. Decedent's Name (First, Middle, Las | (1) | | | | 2. Date of Dea | Day Y | 3. Time of Death |
| | /Medic | al l | Blessing | Gross | | | | 3 | - | 09 23:50 PM |
| d | Examir | er | 4a. Facility Name (If not institution, give | cal Cente | | 4b. City, Town, o | r Locetion of De | ath | 4c. County of | more City |
| | Funeral | | 5. Social Security Number 6. S | | | If Under 1 Year | If Under 24 H | | | Birthplace (State or Foreign Country) |
| Н | Director | | NIA 1 | DM 20 F | Yrs. | Months Days | Hours Mi | | y, Year) 3 2009 | Country) MD |
| | p . | | Usual Residence of Decedent 10a. State 10b. County | 10c Cit | tv. Town or Lo | cation | | | | 10d. Inside City Limits |
| | ehow | 5 | Mh 13 11 | 11 | | | | | | 1 Yes 2 No |
| | the Marylar r 28a-f ehov notified at | Directo | 10e. Street and Number | noie Lity 6 | paltin | 10f. Zip Code | | | 10g. Citizen of Wh | at Country? |
| | 3e or | | 2907 Bright | ~ St | | 20 | 110 | | 11 | CA |
| | daatt | Funeral | 11. Marital Status | 12. Was Decedent Ever in U | .S. 13. V | Was Decedent of H | Iispanic Origin? | (Specify Yes or No- erto Rican, etc.) | - 14. Race - | American Indian, White, etc. |
| 9 | or its | | 1 Never Married 2 Married | 1 ☐ Yes 2 ☑ No If Yes, Give | | | | one moun, ore., | Specify: | vvinte, etc. |
| Ö | within 72 hours aftar death with the Maryland ena. than "neturel", or iteme 23e or 28e-1 ehow he Medical Examinar must be notified at | d by | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed | Year or Dates: | 160 Doors | lent's Usual Occup | ention | | 16b. Kind of Busin | Black |
| 7. | In 72 n "nei dealic | Completed | (Specify only highest gra | de completed) | /Give | kind of work done OO NOT use retired | during most of w | orking | | lessificustry |
| 212 | d with plena. | mo. | Elementary/Secondary (0-12) | College (1-4or 5+) | | NIA | | | NA | |
| P | 2 should be filled with and Mental Hyglens is marked other the eumetic avent, ILE | Bec | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's N | ame (First, Middle, | Maiden Surname) | 3 |
| yiai | Manta Marked arked | 2 | Brandon C. G | ross Sr | | | Cho | antell | Nee | 14 |
| Maryland 21215-0036 | s 1 and 2 should f Health and Man Item 27 is marks other treumatic | | 19a. Informant's Name/Relationshi | ype, Print) | 19b. Mailin | g Address (Street | 4 | Rural Route Numbe | , | |
| | s 1 and 3 Health Item 27 other tr | - | Chantel Neely / m 20a. Method of Disposition | 10 ther 20b. F | Place of Dispo | 7 Srigh | 100 | Date Date | more 20c. Location - Ci | |
| Baitimore, | 0 ° = 5 | | 1 Burial 2 □ Cremation 3 □ | Removal from State | emetery, cren | natory or other plac | | 3-09 | | • |
| 를 | parmit. Peg Department importent: any injury o | 1 | * 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen | | il Car | . Name and Addre | | 201 | Ach | more, ms |
| B | parmit. Dapartrimporte any inju | | BIKA | 1 | 14 | ome 2 | 134 (1) | MANS | MAIN A | 20 21222 |
| | | | 23a. Pert1. Enter the disease, or com shock, or heart failure. List only | olications that caused the deet | h. Do not ente | er the mode of dyin | ng, such as card | ac or respiratory ar | rest, | Approximate Interval Between |
| | Pnysician | | Immediate Cause (Final disease or condition | Diaphro | aam | atic 1 | tern | a | | Onset and Death |
| 1 | /Medical | | resulting in death) | Due to (or as a conseq | | | | | | 111 |
| | Examiner | | Sequentially list conditions, if any, leading to immediate | b. Sireno | | 19 | | | | 4 hours |
| | ad alt | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq | uence of): | | | | | |
| _ | axecutad n and ial-tranait | xan | that initiated events resulting in death) Last | c | uence of): | | | | | |
| 8760, | P P | dical E | | d. | | | | | | |
| 9 | tificata ig phys as tha | Bell | | | | | 200 (8.00) | | | |
| Box | ettanding p for usa as | an/N | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta | | Ectopic pregnancy | , | | 23d. Date of | · · |
| E | The law requires that the death cartific te has bean signed by the ettending p saga 2 should be deteched for use as | Completed by Physician/Me | in the past 12 months? | 4☐Pregnant at time of d | | Other (specify) | | | Month | Day Year |
| P . | d by t | Ph | 9 ☑Unknown Part II. Other significant conditions c | ontributing to death but not rec | ulting in the ur | aderhina cauce an | on in Part I | 23e Did to | phacco use contribu | ite to the cause of death? |
| Ś | lires the signed i | i by | Part II. Other significant conditions o | onthodaig to deal industriatives | alting in the di | idenying cause giv | anniran. | | | Probably 4 Nnknown |
| Š | w raquir baan si should | etec | | | | | | 24a. Was | an Jah Wa | re autoney findinge available |
| Rec | The lay | E G | | | | | | autop gerfor | rmed? dea | re autopsy findings available r to completion of cause of th? |
| ta | | | 25. Was case referred to medical | | | | 26 Place of D | eath (Check only o | | Yes 2200 |
| <u> </u> | Attending Physician: r daath. ector: Aftar this cartific. by the funaral diractor. | To B | examiner? | Hospital: Inpatient 2 | ER/Outpatien | t 3 DOA Oth | | Home 5 ☐ Resid | | (Specify) |
| Ö | ding Phys h. Attar this funaral di | ä | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | y at | | now injury occurred | |
| Sio | Attendin daath. ctor: A y tha fu | catic | 2 Accident investigation | | | | Yes 2 □ No | | | |
| Division of Vital Records, | or Ati | Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, stre by) | eet, factory, office | | 28f. Location (S City or Tox | Street and Number (vn, State) | or Rural Route Number, |
| | Hospital 4 hours a Funeral (| 2 | 29a. Certifier 1 Certifying Ph | ysician: To the best of my kno | wiedne death | occurred at the tig | ne date and pla | ce, and due to the | cause(s) and mann | ar as stated |
| | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Medical | | niner: On the basis of examina and manner stated. | | | | | | |
| _ | within 2 To the compla | Me | 29b. Signature and title of certifier | , | | 29c. Licens | | | 29d. Date signed (/ | |
| | - | | Kenor Gllo | 11 SOX MD | | D3 | 3573 | | 3/13/00 | 1 |
| | | | 30. Name and address of person who | completed cause of death (Item | n 23a) (Type, | Print) | | C 1 0 | D IL | Massla O |
| | | | Renee Ellen Fox | MD 90110 | 24 20 | outh 6 | rceno | Street | DaiTIL | DISOLUTION |
| Š | Sta Registi | | 31. Date filed (Month, Day, Year) MAR 2 4 2009 | Den Signal | . fran | Kel | | | | nore Maryland |

| Yatient Known as - Nechame | Baltimore, Maryland 21215-0036 | In: The law requires that the death certificate be executed 💘 🗦 🕏 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland |
|----------------------------|--|---|
| | Division of Vital Records, P.O. Box 68760, | he Hospital or Attending Physician: The law requires that the death certificate be executed |
| 31 | 1 | To the h |

| | | For | Please | - | aryland / [| k Indelible Ink Department of I | lealth and N | | | ngles | | | |
|--|-------------------|---|-----------------------------------|--|--|--|---|---|------------------------------|--|--|--|--|
| Physicia | ın | 1 - State Registrar 1. Decedent's Name | | st) | 0 . | Certificate of herg | Death | 2. Date of Death Month | Day Year | 3. Time of Death | | | |
| /Medic | al | 7.00710 | ma toot lookitution of | e street and number) | | | r Location of Death | March | 2.0 200 4c. County of Dea | J-1 - W | | | |
| Examin | er | | ii Hospi | ital of B | | re Bulti | nove at | 4. | N/A | rthplace (State or Foreign | | | |
| uneral irector | | 220-04-98 Usual Residence of | 351 ¹ | □м 2ДГ | 0.5 | Yrs. Months Days | Hours Min. | (Month, Day, Ye NOV.26, 192 | ear) C | AND | | | |
| show | _ | 10a. State | 10b. County | | 10c. City, Town | | | | | 10d. Inside City Limits | | | |
| 28a-f s | Director | MD 10e. Street and Nur | | IMORE | | OWINGS MILL: | 5 | 100 | Citizen of What C | 1 □Yes XX No | | | |
| s 23a or 2 ust be n | | 3753 BIR | | | | 2111 | | F | POLAND | | | | |
| Department of Health and Mental Hyglens. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Eventing rust be notified at once. | by Funeral | 11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed | ied 2 Married | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates: | | 13. Was Decedent of No. 1 ☐ Yes 2 ☐ No. | lispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | | | | |
| e. In "natu Medical | Completed | (Spec | 15. Decedent's Ed | ducation ade completed) College (1-4or t | | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | during most of work | ing 16t | o. Kind of Business | s/Industry | | | |
| ygiene er tha t, the | Com | 12 | ridary (0-12) | | J+, | FASHION DES | | | CLOTHIN | IG | | | |
| Mental H arked oth atic eveni | To Be | 17. Father's Name | | | | | 18. Mother's Nam | e (First, Middle, Mail KAUFFER | den Surname) | | | | |
| 27 is mar 27 is mar r trauma | | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| item | | ZIPPI GROSSBLAT / DAUGHTER 3753 BIRCH LANE; OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State | | | | | | | | | | | |
| tment tant: If jury o | | ALM Burial 2 Cremation 3 Hemoval from State MIKRO KODESH BETH ISRAEL 3/22/2009 BALTIMORE, MD | | | | | | | | | | | |
| Uepar Impor any in once. | 3 | 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 | | | | | | | | | | | |
| ٠ | 0.0 | 23a. Part 1. Enter t shock, or hea Immediate Cause | irt failure. List only | plications that cause one cause on each li | d the death. Do ine. | not enter the mode of dy | ng, such as cardiac | or respiratory arrest | , | Approximate Interval Between Onset and Death | | | |
| ysician Medical | | disease or condition resulting in death) a. Aspiration Pneumonia. Due to (or as a consequence of): | | | | | | | | | | | |
| aminer | iner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying | | | | | | | | | | | |
| physician and the burial-trans | dical Examiner | Cause (Disease or that initiated events resulting in death) | 3 | cDue to (or as | a consequence | of): | | | | | | | |
| within £4 hours and exean. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown | | | | | | | 23d. Date of d Month | elivery Day Year | | | |
| signed by | by | | | | | | | | | to the cause of death? Probably 4 Unknown | | | |
| has beer ge 2 shou | Completed | Chron | ic Obstr | | | y Disease | 2 | 24a. Was an autopsy performe | prior to d? death? | autopsy findings available o completion of cause of | | | |
| tificate or, pag | ပ္ပ | Dem: | enta. | | | | 26 Place of Dea | 1 ☐ Yes 2. ☐ th (Check only one) | ŽŃo 1□Y€ | es 2 ⊒Mo | | | |
| nis cer direct | To B | examiner? 1 ☐ Yes 2 덛 | | Hospital: 1 Impati | ient 2 ER/O | utpatient 3 DOA Ot | nor! | ome 5 Residence | e 6 Other (Sp | ecify) | | | |
| n. After th funeral | | 27. Manner of Dear | th 5 ☐ Pending investigatio | 28a. Date of Inj (Month, Da | | Time of 28c. Injury Wo | ıry at rk?]Yes 2 □No | 28d. Describe how | injury occurred | | | | |
| arter dear Director: d in by the | ertification: | 2 Accident 3 Suicide 4 Homicide | 6 ☐ Could not be determined | e 28e. Place of In | jury - At home, fa tc. <i>(Specify)</i> | arm, street, factory, office | | 28f. Location (Stree City or Town, S | | Rural Route Number, | | | |
| e Funeral e Funeral letely fille | Medical C | 29a. Certifier (Check only one) | | | of examination a | e, death occurred at the nd/or investigation, in my | | | | | | | |
| To th comp | Me | 29b. Signature and | bil han | | | RE | se number 5 - 0 0 0 - | | | nth, Day, Year) 20 2009. | | | |
| | | 30. Name and add | ress of person who | completed cause of | death (Item 23a) | (Type, Print) | nital of | Rultima | re | | | | |
| Sta Registr | | 31. Date filed (Mor | th, Day, Year) R & 4 2005 | 32. Regist | trar's Signature | (Type, Print) inai Hosp bares | 0 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Boris G.crelila 1:25 B /Medical 200,9 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1texs WORLD WAST Bock If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/23/1916 9. Birthplace (State or Foreign Country)
BELARUS 6. Sex **Funeral** Months Days Hours Min. 12 M 2 □ F 218-35-0974 92 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, IIv. Madical Exomina is ust be nutflied at Director 1 ☐ Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3410 ASSOCIATED WAY, #424 21117 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? 1 □Yes 2 No 72 hours after 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 WHITE 1 □Yes 2 No If Yes, Give Year or Dates: Specify <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) DOCTOR MEDICINE s 1 and 2 should be filed wi f Health and Mental Hygier item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MOISEY GORELICK NESSY EISENSTADT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If item 27 i
any Injury or other tre ROZALIA GORELIK / WIFE 3410 ASSOCIATED WAY, #424, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 103/23/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MYO CONTILL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed and I-trai mat initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, burial physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, s been signe should be c Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed/ Physician: The certificate | Division of Vital 1 ∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) examiner? Decl-nes 1 DYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After remaletely filled in by the fune 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

5401

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J-

129085

2009

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #29d Per Phy C8893/24/09 Jh
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 12:53 A March 18 2009 Mary Hoffman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Laurel 348 Dameron South If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1931 1 □ M 2 😾 F Washington, D.C. August 6, 77 Yrs. 578-40-0080 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. M. dieal Evantimer, until be natified a once. 28a-f show 1 ☐ Yes 2 No Anne Arundel Laurel Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20724 U.S.A. 348 Dameron South Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ∐Yes 2/12XNo Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Sinyard James Barringer မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurel, Maryland 20724 (Husband) 348 Dameron South Karl Hoffman 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 3-21-2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, Maryland 20707 21. Signature of Funeral Service Licenses Thoose 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Drews Cancer ZImonth **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 No 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 20,2009 lano 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Musel 31. Date filed (Month, Day, Year) State Registrar

| Robert Wayne Hans | ell 1- For State | State of Maryla | and / Departme <i>Certifics</i> | ent of Health a ate of Death | nd Mental Hy | | 200 | 9 1917 |
|--|---|--|--|---|---|------------------------------------|---------------------------------------|--|
| | Registrar 1. Decedent's Name (Fire | st, Middle,Last) | // | | | Reg. I | | 3. Time of Death |
| Medical Examiner | Kob | est W. | Hanse | | or Location of Death | Month Da March 20, 20 | 4c. County of Death | 0205 hrs |
| (| 2831 Liberty Pa | institution, give street and ni irkway | umber) | Dundalk | or Eccation of Death | | Baltimore Cour | nty |
| Funeral Director | 5. Social Security Number | er 6. Sex | 7. Age (In yrs. last birt | | ear If Under 24Hrs. ays Hours Min. | 8. Date of Birth (N | | nplace (State or Foreign ntry) |
| | Usual Residence of Dec | 116 | | | | // | /// | 40d Inside City Limite |
| ow any | 10a. State 10b. | County | 10c. City, Town | 1-11 | | | | 10d. Inside City Limits 1 Yes 2 No |
| the Maryland a or 28a-f shu uified at once Director | 10e. Street and Number | DUITI MORE | Dur | 10f. Zip Code | 9 | 10g. | Citizen of What Coun | try? |
| the Ma Sa or 28 Direct | 2831 | Liberty | Parkwo | u/ 21. | 222 | | USA | |
| "MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland realth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 11. Marital Status 1 Never Married | 2 Married 12. Was De Arried F 1 Yes | ecedent Ever in U.S. Forces? | 1/3. Was Decedent of If Yes, specify Cub | Hispanic Origin? (Spe ban, Mexican, Puerto F | cify Yes or No- Rican, etc.) | 14. Race - Americ White, etc. | an Indian, Black, |
| s after de ral", or niner mu by Fu | 3 Widowed 4 | Divorced If Yes, Give Ye or Dates: | ear Vietnam | 1 Yes 2 VI | | ork done 116 | Specify: (1) | (/te |
| 2 hours "natur | 15. Decedent's Educat Elementary/Secondar | tion (Specify only highest gra ry (0-12) College | | during most of working l | | | | , door, |
| 5-0036 led within 72 bour Hygiene. I other than "natt the Medical Exar Completed | 12 | | | Lot. | MAN | | Thompson | Mercury |
| Tore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by I | 17. Father's Name (First | , Middle, Last) | | | 18.Mother's Name | First, Middle, Mai | den Surname) | |
| 2121; ould be fil J Mental I s marked ite event, | 19a. Informant's Name/F | Relationship (Type, Print) | 19 | b. Mailing Address (St | reet and Number or R | ural Route Numbe | er, City or Town, State | Zip Code) |
| e, MD L and 2 sho Health and item 27 is | KathRYN | 1 Hanse/1 - 1 | WIFE & | of Disposition (Name of | cemerery Lar | Date 12 | Duy da /k/ 20c. Location - City or | Town, State |
| S S S S S S S S S S S S S S S S S S S | 20a. Method of Disposit 1 Burial 2 | Cremation 3 Removal | | tory or other place) | 2 4 1 1 - | 21/20 | Bo Him | c- ml |
| Baltimore, permit. Pages I a Department of He Important: If ite | 4 Donation 5 21. Signature of Funera | Other Specify: | Day | 22. Name and Addr | ress of Famility R | d/+11- | ASKER! | EUNERAL |
| Per Per Per Per Per Per Per Per Per Per | Litt | all | | Home, P. | A, 2134 | Willow | Spring 1 | R0/21222 |
| Physician Medical | | sease, or complications that ne cause on each line. | | | | respiratory arrest | , shock, or heart | Approximate Interval Between Onset and Death |
| xaminer | Immediate Cause (Fina or condition resulting in | | sive Atheroscleroti | c Cardiovascular I | Disease | | | |
| | Sequentially list condition | ons, b. | s a consequence of): | | | | | |
| mine | if any, leading to immed cause. Enter Underlyin (Disease or injury that i | ng Cause | | | | | | |
| Exa | events resulting in deat | | s a consequence of): | | | | | |
| ialiar e | UNPENDED | AMENDED |) | | | | | |
| O 0 3.5 0 | IF FEMALE: 23b. Was decedent preg | and the state of t | s, outcome of pregnancy e birth | 2 Fetal death | 3 Ectopic pregna | ncy | 23d. Date of deliver | / Day Year |
| Box 6876 e death certificate the attending phy ed for use as the l hysician/M | past 12 months? | 4 Pre | gnant at time of death | 5 Other (Specify) | | | | |
| D. Bo the dea by the a sched fo | Part II. Other significa | 0 0 | known g to death but not resulting | ng in the underlying cau | se given in Part I. | 23e. Did toba | acco use contribute to | the cause of death? |
| P.O. es that the signed by be detach | ` | | | | | 1 Yes | 2 No 3 Pro | pably 4 V Unknown |
| ords, v requii | | | | | | 24a. Was an autopsy | prior to | topsy findings available completion of cause of |
| Records, The law require, ficate has been sig. page 2 should be Completed | | | | | | perform 1 V Yes 2 | | es 2 No |
| ician: ician: s certifi rector, Be C | examiner? | to medical Hospital: | Inpatient 2 ER/0 | 26.P Outpatient 3 DOA | Other Nursin | | esidence 6 🗸 Othe | r; Scene |
| of Vigenthisineral differential | | No 28a. Da | | | Injury at Work? | | w injury occurred | |
| ion (tendin tendin tor: A tor: A the fur | 1 V Natural 5 | Pending | | | Yes 2 No | | | |
| Division of Vital Records, spiral or Attending Physician: The law require nours after death. neral Director: After this certificate has been signified in by the funeral director, page 2 should be Certification: To Be Completed | 3 Suicide 6 | Could not be determined (Specific | lace of Injury - At home, | farm, street, factory, offi | ce building, etc. | 28f. Location (Str or Town, Sta | | ural Route Number, City |
| C File billing | | rtifying Physician: To the b | pest of my knowledge, d | eath occurred at the time | e, date and place, and | due to the cause | (s) and manner as star | red. ne cause(s) |
| To the IIG within 24 To the Fu completely | one) 2 ✓ Me 29b. Signature and title | and manne | er stated. | | cense number | | 29d. Date signed (Mo | |
| | Caro | re face | den | | .C.M.E. | | March 20, 2009 | |
| [4] | 30. Name and address Carol Allan, M | of person who completed co | ause of death (Item 23a al Examiner 111 |) 1 Penn Street, Bal | timore, MD 2120 | 1 | | |
| State | | | Begistrar's Signature | 7 10 | | | <u> </u> | |
| Registra DHMH 17 Rev 1/2001 | man | 2 4 2009 J | E O | RIGINAL | | | | |

OCME

DHMH 17 Rev 1/2001 OCME 2006

| | | - | For State Registrar | State of Ma | | l / Depa | | t of H | lealth a | | lental Hy | | 2009 | 9 0 | 91 | 72 |
|--------------------------------|--|------------------|---|---|---------------------------------------|---|---|--------------------------------------|-----------------------------------|------------------------|--|--|------------------------------------|---------------------------|---------------------|-----------------------|
| | Physici | | 1. Decedent's Name (First, Middle | E. Doroth | v Ino | ram | | | | | 2. Date of De Month March | Da | | | ne of Dea | ath A ^M |
| | /Medio Examin | | 4a. Facility Name (If not institution | | | Lean | 4b. City, | Town, or | Location of | of Death | Harch | | County of Dea | | 17 | Π |
| | | | Shady Grove Ad | | | | | | lockv | | | | Montg | omery | 7 | |
| - 1 | Funeral | | 5. Social Security Number 577-01-4993 | 6. Sex 7. Ag 1 ☐ M 2 ☒ F | ge (In yrs. la. | st birthday) Yrs. | If Under Months | Days | If Under Hours | Min. | 8. Date of Bir (Month, Da Sept • | th a <i>y, Year)</i> 1. C | 9. Bir | thplace (S | tate or Fo | oreign |
| | Director | | Usual Residence of Decedent | | 91 | | | | | | sept. | 9, 13 | II was | hingt | OII, 1 | D.C. |
| | ryland how | _ | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | | | 10d. Insi | , | |
| | 8a-fs | ecto | | gomery | | | | | sburg | 3 | | 10 00 | | | Yes 2 | |
| | s filed within 72 hours after death with the Maryland il Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Exprinter mast be restified at | Funeral Director | 10e. Street and Number 333 Russell Av | zonuo #/i02 | | | 10f. Zip | | 877 | | | | tizen of What Co ted Sta | | | |
| | ns 23 | era | 11. Marital Status | 12. Was Decedent | Ever in U.S. | . 13. | Was Deced | | | igin? (Spe | ecify Yes or No Rican, etc.) | | 14. Race - Am | erican India | an, | |
| 9 | after o | | 1 ☐ Never Married 2 ☐ Marri | Armed Forces? ied 1 ☐ Yes 2 🛣 If Yes, Give | No | | lfYes,spec 1∐Yes 2 | | | n, Puerto | Rican, etc.) | | Black, Whit | e, etc. | | |
| 003 | ural", | d b | 3 XWidowed 4 ☐ Divorced | Year or Dates: | | | | | | | | | | hite | | |
| 15- | n 72 h "natu | Completed by | 15. Decedent (Specify only highes | | | 16a. Dece (Give | dent's Usua kind of wor DO NOT us | al Occupa rk done d se retired | ation <i>luring mosi</i> l) | t of worki | ing | 16b. K | ind of Business | /Industry | | |
| 212 | within jiene. | E O | Elementary/Secondary (0-12) 1 2 | College (1-4or 5 | 5+) | | f-emp] | | | | | В | usiness | Owne | r | |
| ď | al Hyg l othe vent, | Be C | 17. Father's Name (First, Middle, I | | | | 1 | | 18. Mothe | | (First, Middle | | | | | |
| ylaı | ould b Ment arked atic e | 은 | Lawrence Wi | | | | | | | | cances | | | | | |
| Mar | iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Exprimer must be notified at | - Commission | 19a. Informant's Name/Relationsh Sally P. Baer/F | | | | • | | | | | - | or Town, State, e, Penns' | | i = 10 | 9/126 |
| <u>.</u> | 1 and Healt tem 2 | | 20a. Method of Disposition | TIERA | 20b. Pla | | | | | | | | ocation - City or | | | |
| E O | Pages ent of nt: If if | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si | | Par | ice of Dispo metery, crei Klawn Parl | "Memoi | rial | <i>e)</i> [[Y] | larch 2 | 009 | Rocl | kville, | Marv1 | and | |
| Baltimore, Maryland 21215-0036 | permit. Pages 'Department of H Important: If ite any injury or of | | 21. Signature on Funeral Service I | | M0019 | 98 R | Name and Dert | d Addres | S of Facilit Pumph | rey | Funera. | l Hor | me/Beth MD 208 | esda- ase | Chev Inc. | У |
| 1-1 | | | 23a. Part 1. En ir the disease, or shock, or heart failure. List | complications that caused | d the death. | Do not en | ter the mod | e of dyin | g, such as | cardiac | or respiratory a | rrest, | 110 200 | Approx Interva | cimate Il Betwee | en |
| | Physician | | Immediate Cause (Final disease or condition | | estiv | | | | | | | | | Onset | and Deat | ıth |
| | /Medical Examiner | | resulting in death) | Due to (or as | | | | | | | | | | | | |
| | _xa.iiiioi | ja | Sequentially list conditions, | b Due to (or as | a conseque | ence of): | | | | | | | | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | , | | | | | | | | | | |
| ó, | be executed ician and ourial-transit | | resulting in death) Last | Due to (or as | a conseque | ence of): | | | | | | | | | | |
| 8760, | ate by | dical | | d | | | | | | | | | | | | |
| Box 68 | eath certificate be executed attending physician and for use as the burial-transit | n/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | of pregnan | су | 7 | | | | | | 23d. Date of de | livery | | |
| | requires that the death leen signed by the atter nould be detached for u | Physician/Medi | in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown | 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | | | ☐ Ectopic p ☐ Other <i>(sp</i> | | y | | | | Month | Day | Year | ,r |
| Р.О | s that t ned by e detac | by Ph | Part II. Other significant condition | ons contributing to death b | out not result | ting in the u | nderlying ca | ause give | en in Part I. | | 23e. Did | tobacco | use contribute t | o the cause | e of deatl | th? |
| rds | equires en sig ould be | ed b | Sepsis | | | | | | | | 1 🗆 | Yes 2 | √ No 3□ P | robably | 4 🗌 Unkr | nown |
| ecc | law re las be 2 sho | Completed | | | | | | | | | 24a. Was | DSV | 24b. Were a | utopsy find completion | lings avai | ilable se of |
| <u> </u> | : The cate h | Con | | | | | | | | | perfo 1 □ Yes | ormed? 2 🔀 No | death? | s 2 🗆 No | _ | |
| Vita | ician certifi ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Oth | or: | | n (Check only | | | | | |
| of | Phys r this ral dii | <u>ان</u> | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 28a. Date of Iniu | ent 2 🗆 E | 28b. Time o | | Bc. Injur Work | 4 L N | | me 5 Res 28d. Describe | | 6 ☐ Other (Sperry occurred | ecify) | | |
| ion | nding tth. :: Afte e fune | tion | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig | g (Month, Da | ay, Year) | Injury | м | | ć? Yes 2 🗍 | | | • | , | | | |
| Division of Vital Records, | or Atter fer des irector n by th | Certification: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Hornicide determ | ined 20e. Place of Inj | jury - At hon tc. <i>(Specify)</i> | | eet, factory | , office | | | 28f. Location (City or To | | nd Number or Fi | ural Route | Number | r, |
| (1) D | To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached | ical Ce | (Check only 2 Medical | ng Physician: To the best Examiner: On the basis of | of examinati | rledge, deat | h occurred evestigation | at the tir | me, date ar | nd place, ath occur | and due to the | e cause(s , date an | s) and manner a d place, and du | is stated. e to the ca | use(s) | |
| 0 | ithin 2 orthe | Medical | one) 29b. Signature and title of certifier | and manner st | rated. | | 290 | . Licens | e number | | | 29d. Da | ate signed (Mon | th, Day, Ye | ar) | |
| | ĕ≱≓ŏ | | De DI | me/ | | | | | D64 | 502 | | | rch 20, | | | |
| | | | 30. Name and address of person Brian Carpenter | who completed cause of | death (Item | 23a) (T ype, | Print) | | | | | | | | | |
| | | | | | | | Jenter | r Dr | ive, | Kock | ville, | Mary | yLand : | 20850 | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | | rar's Signatu | | arke | , | | | | | | | | |

DHMH 17 Rev 1/2001

| | | - | State of Maryland / Department of Health and M State Registrer State Of Maryland / Department of Health and M Certificate of Death | | ene 009 | 09173 |
|------------|---|---------------------|--|--------------------------------------|----------------------------------|---|
| | Physicia /Medic | | 1. Decedent's Name (First, Middle, Last) EDGAR HENRY JOHNSON | 2. Date of Death | Day Year | 3. Time of Death |
| } | Examin | er | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chesapeake Hospice House Linthicum | | 4c. County of Deat | |
| | 5 | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | 9 Birt | hplace (State or Foreign untry) |
| | Funeral Director | | 449-90-9081 12 M 2 F 58 Yrs. Months Days Hours Min. | Nov 24, | 2009 Ter | _{untry)} nessee |
| | g , | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | ehov | 7 | | | | 1 ☐ Yes 2 ☑ No |
| | the M | ecto | Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of What Co | |
| | with the tree | ā | 16031 Dorset Road 20707 | | USA | |
| | death me 2; | nera | 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spr | ecify Yes or No- | 14. Race - Ame Black, Whit | |
| 9 | or Ite | by Funeral Director | 1 Never Married 2 Married 1 Yes 2 No 1970 | rnoari, otc.) | Specify: B1 | _ |
| 8 | within 72 hours after death with the Maryland ene. than "neturel", or lieme 23a or 28e-f ehow ha Madical Ezaminar must ka notified at | q p | 3 Wildowed 4 Wilvorced Year or Dates: 1970 | 1 4 | 6b. Kind of Business/ | |
| 7 | in 72 "neil | ojete | (Specify only highest grade completed) (Give kind of work done during most of work) | ing | ob, King of business | industry |
| 21215-0036 | d with giene. | Completed | Elementary/Secondary (0-12) College (1-4or 5+) 4 Graphic Artist | | Self Empl | oyed |
| pu | al Hy d other | Be | 17. Father's Name (First, Middle, Last) 18. Mother's Name | | laiden Sumame) | |
| Maryland | ould i | 2 | | yn Grant | | |
| Mai | d 2 sh th and 7 is n treun | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 500 Largo Center Drive | | | |
| ē, | Heal tem 2 other | - | | | Oc. Location - City or | |
| E | Pages ient of nt: If ry or | | 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 03/2 | 3/09 | Baltimore, | Marvland |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel; or Iteme 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at once. | | 21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society 299 Frederick Road | | and, Inc. | |
| | 707 e Q | | Thomas Gregor 299 Frederick Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or | | | Approximate |
| | Diam'r Isaa | | shock, or heart failure. List only one cause on each line. | or respiratory arro | 51, | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) Due to (or as a consequence of): | | | 1000 (11) |
| | Examiner | | Sequentially list conditions b | | | |
| 2 | sit ad | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | |
| 20 | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit | Examiner | resulting in death) Last C. Due to (or as a consequence of): | | | |
| 8760, | e be e | | d | | | |
| 9 | ntificate ng phys | Medi | IF FEMALE: | | | |
| Вох | death certifica attending ph | lan/ | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy | | 23d. Date of del Month | ivery Day Year |
| P.O. I | at the de by the a tached f | Physician/Medical | 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown 5 □ Other (specify) | | | |
| | res thet the igned by be detacted | by Ph | Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tob | acco use contribute to | the cause of death? |
| rds | w requires been sign should be | | | 1 ☐ Ye | s 2.2 No 3□Pr | obably 4 Unknown |
| Records, | e law requ has been ge 2 should | Completed | | 24a. Was an | prior to | topsy findings available completion of cause of |
| E . | icete har, page | Com | | perform 1 ☐ Yes 2 | ed2 death? | 2 No |
| Vital | yeician: is certific director, | Be | examiner? | h (Check only one | , / 1 | House |
| of | | . To | 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at | ome 5 Resider | | Holpice |
| ion | Attending Phyr death. sctor: After thi by the funeral | atior | Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | | | |
| Division | r Attencier death | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Str. City or Town, | eet and Number or Ru , State) | ural Route Number, |
| | oitel o urs aft orel DI | | | | | |
| | To the Hospitel or Attenc within 24 hours after death To the Funerel Director; completely filled in by the | ledical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, the discontinuous control of the date and place, and the discontinuous control of the date and place, the date and place, the date and place, and the date and place, and the date and place, and the date and place, and the date an | red at the time, da | te and place, and due | to the cause(s) |
|) | To To | M | 29b. Signature and title of certifier 29c. License number NY3 | | Menter Signed (Monte | 23,2009 21,2009 11,10021401 |
| | | | 1 de la constitución de la const | f* | Λ | |
| | \ | | 39. Name and address of person who completed cause of death (tem 23a) (Type, Prim) FYENSE IT | MAHWA | MANNAPI | LI, MO21401 |

| | | State of Maryland / Department of Health and Mental Hygiene 1- State Beginter: Certificate of Death Beg No. 2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2-2- | | |
|---|---------------------|--|-------------------|----|
| | | Reg. No. 1. Decedent's Narge (First, Middle, Last) 2. Date of Death 2. Date of Death | eath | |
| Physicia /Medic | al | Modeline 4a. Facility Name (If not institution, give street and number) Jeromin Month Day Year 9 9:30 4b. City, Town, or Location of Death 4c. County of Death | А м | |
| Examine | er | The Johns Hopkins Hospital Baltimore City | | |
| Funeral Director | | 5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 216-12-8580 85 Yrs. 9. Birthplace (State or Fig. 1) 1 M 2 F 85 Yrs. 9. Birthplace (State or Fig. 2) 1 Months Days Hours Min. 1 July 13, 1923 Maryland | oreign | |
| pug w | | Usual Residence of Decedent 10a. State | Limits | |
| Maryla | ţo | Md. Baltimore City 1x Yes 2 | □No | |
| r 28a notifi | irec | 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? | | |
| th with | a D | 334 South Bouldin Street 21224 U.S.A. | | |
| d 21215-0036 filed within 72 hours after death with the Maryland Flyglene. ther than "natural", or items 23a or 28a-f show in, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. | | |
| 5-0036 72 hours aft natural", or | ed | 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry | | |
| 215 tthin 72 e. an "na Medic | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th (Give kind of work done during most of working life. DO NOT use retired) Telephone Operator C & P Telephone | α. | |
| 21 ed wit vgiene vgiene i, the | Con | 8th Telephone Operator C & P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) | | |
| re, Maryland 21215-C s 1 and 2 should be filed within 72 he if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical | To Be | John Panek Katherine Krol | | |
| Mar 2 sh 2 sh and ' is m raum | | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Jeromin (son) 334 South Bouldin Street Baltimore, Md. 21 | 22/ | |
| re, M s 1 and 3 of Health item 27 other tr | | 20a. Method of Disposition | | |
| | | 1 Mourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Stanislaus Cem 3-25-2009Baltimore, Maryla | nd | |
| Baltimore, permit. Pages 1 a Department of He Important: If item any injury or othe | | 21. Signature of Funeral Service Licensee St. Staffslaus Celli 3-23-2009Balt Inforce, Maryla 22. Name and Address of Facility Kaczorowski funeral Home 1201 Dundalk Avenue Baltimore, Md. 21 | , PA | |
| | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | |
| Physician /Medical | | shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last List only one cause on each line. Interval Betwee Onset and Death Conset and Deat | ath | |
| Examiner | | Muccarried in bacchies | | |
| | ner | Sequentially list conditions, if any, leading to immediate b. Our to or as a consequence of): | | |
| 8760, A cate be executed physician and the burial-transit | Examine | The arty, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events Commonwealth of the initiated events are consequence of): | | |
| e exec | | resulting in death) Last Due to (or as a consequence of): | | |
| 8760, cate be ex physician as the buria | edical | d | | |
| Box 6 | | Physician/Me | | ar |
| P.O. hat the detache detache | / Ph) | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death part I. | ith? | |
| cords, F w requires that been signed b should be deli | d by | 1 Yes 2 No 3 Probably 4 Unk | known | |
| Records, he law requires the has been signerage 2 should be. | Completed | 24a. Was an autopsy findings average performed? 1 □ Yes 2 No 1 □ Yes 2 □ Yes 2 □ No 1 □ Yes 2 □ Yes 2 □ No 1 □ Yes 2 | ailable ise of | |
| Vital Residian: The law | Be C | 25. Was case referred to medical 26. Place of Death (Check only one) | | |
| of Vi | 일 B | examiner? 1 Yes 2X No | | |
| n of ng Physter this uneral d | | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work? | | |
| isio tendir leath. or: Af the fu | cati | Accident investigation M 1 Yes 2 No | ar. | |
| Division or Attending I after death. Director: After In by the funer | Certification: | 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 4 ☐ Homicide 5 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Could not be determined 8 ☐ Could not be determined 9 ☐ Could not be determined 9 ☐ Could not be determined 9 ☐ Could not be determined 9 ☐ Could not be determined 9 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be determined 10 ☐ Could not be | ч, | |
| Division of Vital Re- To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical C | 29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | |
| o the vithin of the complex | Me | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | |
| F>F0 | | LA 7/h MD Res-000 March 20,2009 | | |
| 6 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 2: | 1287 | |
| Sta | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | |
| Registr | ar | MAR 2 4 2009 But A Save | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b-c State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mary Virginia Karl 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORI Air Health TRenab Ctr Bel Aic 8. Date of Birth (Month, Day, Year)

Nov. 11, 1918 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F 90 216-09-1154 Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10d. Inside City Limits 10b. County 28a-f show Maryland Harford Co. Jarrettsville 1 ☐ Yes 2√☐ No ral", or items 23a or 28a-f st Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4106 Crown Hill Road 21084 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ ₩idowed 4 Divorced natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "I amy injury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Sales Unknown Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Arthur Foxwell (Friend) 4106 Crown Hill Road, Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Evans Funeral Chapel

Funeral Address of Facility 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee Sus Jun 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cerebro vascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifies Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 15, 2009 D0063981 M.D-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Havre de Grace, MD Benjamin Lee, MD 669 Revolution 31. Date filed (Month, Day, Year) State 2 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Harold Knight 11:45 a[™] 18, 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 512 Limerick Circle Unit <u>Baltimore</u> Timonium 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1√ M 2□ F Months Hours Min. June 11, 216-74-7086 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2√ No MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 512 Limerick Circle, Unit 102 U.S.A. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2X☐No Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Appliance Repair Appliances 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Harold Knight, Sr. Ruth Cash Wanda ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melvin A. Jackson, Sr-step-father 512 Limerick Cir., Unit 102 Timonium, MD 21093 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State LoudonPark 3/21/09 Cemetery: Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service InseeWilliam G. Dau 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Mi. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a NOUTE MYDUARDIAL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PRIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 5 YBARS INCONTROUBD the burial-tran Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ٤ 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes completely filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy After this certificate 1 ☐ Yes 🗡 No of Vital e Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

4

State Registrar Christopher Zajac, M.D.
31. Date filed (Month, Day, Year)
MAR 2 4 2009

9649 Belair Road
32 Registrar's Signature

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 0651 AM March 2000 Marcella /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Johns Hopkins Bayujew Medical Ruler Bultimore 8. Date of Birth (Month, Day, Year) May 30, 1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex Mary land **Funeral** Months 1 ☐ M 2 🖫 F 80 220-24-3623 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Baltimore N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 5010 Oaklyn Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status White 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify: 9 Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy.
Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Emma Lentz Charles L. Heil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5010 Oaklyn Avenue Baltimore Maryland 21206 James G. Kline/ Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Timonium Maryland Dulaney Valley Mem. Gardens 3/23/09 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 53055 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NOUV **Physician** Diva tord /Medical Due to (or as a consequence of) 3 days Examiner ntracerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 1 Hakitown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 MO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 | Yes 2 | **★**0 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hou

To the Fune

completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20,2009 185-000 Mourch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) www yayo easern Avenue Builtimore Shourie Hrijail 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OTH KIASCA lanch 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 8. Date of Birth (Month, Day, Year) 7. Age (In y s. 9. Birthplace (State or Foreign **Funeral** Months Hours 1 □ M 2 ▼ F 86 9745 Director MARYUNI 001088117,1922 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Maryland N/A Baltimore 1X Yes 2 No Director 10e. Street and Number 5407 Creston Avenue 10f. Zip Code 21214 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à Specify: Withis 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Book keeper State of Maryland or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank I. Kocyan Louise Janka ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Kirsch/Daughter 5407 Creston Avenue Baltimore Maryland 21214 Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. Inluny 3/19/09 Towson Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. Inc los 5305 Harford Róad Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 14541 -ON62151VI /Medical Due to (or as a consequence of) Examiner INPATUTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed LORONATIN Due to (or as a consequence of P.O. Box 68760 attending physician for use as the buria Physician/Medical as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1☐ Yes 2☐No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. F Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) \$2. Registrar's Signature \$1. April 10. Ap

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Louit RAVENBLYA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per 1h g890 4-2-09 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** LIVINA Keener TAIZCIT 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Loch Raven Veterans Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Nov. 6, 1928 Social Security Number Sex 1XXXM 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 217-22-1441 80 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Yes 2 □ No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21211 USA 3838 Roland Avenue # 1304 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. Specify: ≥ 3 Widowed 4 □ Divorced Year or Dates: 1947-50 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
Unknown College (1-4or 5+) Paper Delivery Baltimore Sunpaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertie McCallister McAlister Irving Keener, Sr ျ 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 14 Broadridge Lane, Lutherville, Maryland 21093 19a. Informant's Name/Relationship (Type. Print)
Donald Keener, Sr. Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any Injury or ot
once. Maryland VA Cemetery 3/27/2009 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest, MD ²² Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland neral Service Licens 21. Signatur 1 of Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hronic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed Yes 2 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 16 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Deal 28b. Time of 28c. Injury at/ Work? 28d. Describe how injury occurred Injury Natural 2 Accident 5 Pending ours after death.

neral Director; Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie of person who completed cause of death (Item 23a) (Type, Print) It RAVEN Blut, Ba Ho, TH ZIZI8 3900 LOC Werthame 31. Date filed (Month, Day, Year) MAR 2 4 2009 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 4:23 A M March 23 Mary Patricia Lance 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 12 Terrace Drive Linthicum Heights | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | | FEB 2, 1932 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 😿 F Maryland 77 212-28-5826 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Anne Arundel Linthicum Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21090 USA 12 Terrace Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u> Health Care</u> 12 Private Duty Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mae Freeze William Falter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Terrace Dr Linthicum Heights, MD 21090 Carole Schleicher/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 3/23/09 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring cremation Society of Maryland, Inc. ald o 299 Frederick Rd Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Be

MD

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the burial

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Examiner Physician/Medical ģ Be Completed Certification: To

| | Immediate Cause (Final disease or condition | MulaAsti | - Conce | <u>/</u> | | | Cm Ks | sws. |
|--------------------------------|---|--|----------------------------|---|--|--------------------------|---|------------------------------|
| | resulting in death) | Due to (or as a conseque | nce of): | | | | | |
| iner | Sequentially list conditions, if any, leading to immediate | | | | | | | |
| ical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseque | nce of): | | | | | |
| Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea | eath 3 Ectopic | | | 23d. Date of de Month | elivery Day | Year |
| eted by Ph | Part II. Other significant conditions con Hypullron | ntributing to death but not result | ing in the underlying | cause given in Part I. | | □ No 3□ F | Probably 4 | Onknown |
| Comple | Hirth & Colm to | w Ligh | mollow | | 24a. Was an autopsy performed? 1 ∐Yes 2 🖼 | death? | utopsy findi completion s 2 \(\sumbole No | ngs available of cause of |
| Be (| 25. Was case referred to medical examiner? | / / | | | ath (Check only one) | | | |
| | 1 Yes 2 XNo | lospital: 1 ☐ Inpatient 2 ☐ E | R/Outpatient 3 🔲 [| OOA Other: 4 Nursing | Home 5 Residence | 6 ☐ Other (Sp | ecify) | |
| ation: | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day, Year) | 8b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how inju | | | |
| Medical Certification: To | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hom building, etc. (Specify) | e, farm, street, facto | ry, office | 28f. Location (Street at City or Town, State | nd Number or F e) | lural Route | Number, |
| dical (| | sician: To the best of my know ner: On the basis of examination and manner stated. | | | | | | se(s) |
| Me | 29h Signature and title of certifier | 7 | 2 | 9c. License number | 29d. Da | te signed (Mon | th. Dav. Yea | ar) |

belink from to 200 Cotmos He NO 7122x

29d. Date signed (Month, Day, Year)

2001

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 2 4 2009

12 405 \$32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 17,2009 **Physician** 7:50 AM Lowe Pauline /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 1940 Frames Road 8. Date of Birth (Month, Day, Year) April 12,1934 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min Months 1 M 2 K Pennsylvania Director 215-30-4091 74 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10h County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Experient must be notified at 1 □Yes 2X No Dunda1k Director MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the M Department of Health and Mental Hygiene. Important: If item 27 is marked other than "not any injury or other traumatic. 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number United States 21222 1940 Frames Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: þ White **¾**Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools School Bus Driver 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Stevenson ဂ္ Raymond Bartels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1900 Dineen Drive Dundalk, Maryland 21222 Charles David Lowe (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State Middle River, MD Holly Hill Mem. Gdns. 3/20/2009 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fire ral Service 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, with 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, Due to (or as a consequence Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: he law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p (F FFMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the hould be detached 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2**X** No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 🗚a. Was an performed? 1 □ Yes 2 No certificate ! 2/200 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diaa Mikhail, M.D. 1005 North Pt. Road Suite 708 21224 Baltimore, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 4 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician eibowitz 02:54 AM March 22 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 03/30/1945 213-50-1057 63 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 X No Director MD ANNE ARUNDEL **GAMBRILLS** 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2608 CHAPEL LAKE DRIVE, #407 21054 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 \(\tilde{\text{L}} \) Yes 2 \(\text{L} \) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married ь Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE by Specify: 3 Widowed 4 X Divorced "naturai" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other any injury or other traumment. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) **ATTORNEY** LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEIBOWITZ HENSCHEL မ NECHAMA RABINOWITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHONI LABOWITZ / SISTER 11450 SW 16TH ST., DAVIE, FL 33325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LUBAWITZ NUSACH ARI 03/23/2009 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final hermation **Physician** Cerebral 5 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner multiple embolu stroke week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner persiskent MRSA backrennia lureek or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner?

1
Yes

No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \sum Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Natural Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. P.O.

Division of Vital Records,

To the Funeral I To the

> State Registrar

Shabina 31. Date filed (Month, Day, Year)

determined

29c. License number RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Dav. Year) March 22, 2009

Johns Hapkins tospital

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

4 - Homicide

29b. Signature and title of certif

29a. Certifier

Medical

A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O O O

| | | 1 | For State Registrar | State of Mary | • | artment of Healt rtificate of Dea | | Reg. No. | U9 U | 9100 |
|---------------------|---|----------------|--|---|------------------------------------|---|--|---|---|--|
| X | Physicia | - 1 | Decedent's Name (First, Middle, I Mayza | Nicole | Live | -1v | 2. Date Marc | | | Time of Death 8:56 a ^M |
| | /Medic | | Maya 4a. Facility Name (If not institution, g | | 177.4 | 4b. City, Town, or Locat | ion of Death | 4c. Cou | nty of Death | |
| | | | Greater Balti | | | | WSON | | ltimor | |
| e A | Funeral Director | | None | . Sex 7. Age (III | n yrs. last birthday) Yrs. | Months Days Hou | irs Min. (Mont | of Birth h, Day, Year) h14,2009 | 9. Birthplace Country) MD | (State or Foreign |
| | and w | } | Usual Residence of Decedent 10a. State 10b. County | 10 | Oc. City, Town or Lo | ocation | | | 10d. | Inside City Limits |
| | Maryl | tor | Md n/a | | Baltimo | re | | | | 1XYes 2□No |
| | th the | Director | 10e. Street and Number | | | 10f. Zip Code | | 10g. Citizen | of What Country? | |
| | ath wi | | | Rogers Ave. | : 110 | 21209 | Origin? (Capaity Vac | | J.S.A. Race - American I | ndian |
| 036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23s or 28s-f show or other traumatic event, the Macical Examiner must be inclined at | by Funeral | 11. Marital Status 1★ Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Was Decedent of Hispanic If Yes, specify Cuban, Me 1 ☐ Yes 2 ☐ No Spe | | | Black, White, etc. Specify: Black | |
| Maryland 21215-0036 | within 72 ho ene. than "natur the Medical | Completed | 15. Decedent's (Specify only highest : Elementary/Secondary (0-12) | | (Give | dent's Usual Occupation kind of work done during DO NOT use retired) | most of working | | f Business/Indust | ry |
| 2 | filed wi Hygien other th | | n/a 17. Father's Name (First, Middle, La | ect) | | n/a | Nother's Name (First, M | n/ liddle Maiden Sun | | W 7 |
| and | uld be fi fental H rked otl tic ever | Be c | | velv | | 13. 14 | Nicole | Grimes | 7411707 | |
| 3 | 2 should be and Mental is marked aumatic ev | ဥ | 19a. Informant's Name/Relationship | | 19b. Maili | ng Address (Street and Ni | | | wn, State, Zip Co | de) |
| ž | and 2 ealth a n 27 is | | Malik Livel | | | West Rogers | | | | |
| Baltimore, | Pages 1: | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 | ☐Removal from State | * | matory or other place) | Date | | on - City or Town, | State |
| Ē | t. Pa rtmen rtent: | | *4 □ Donation 5 □ Other (Special Service □ | | 2: | tCrematory | March20,2 | | | |
| Ba | permi Depa Impo any ii | | S S | | | 2 Name and Address of F CALVIN B. SC 1412 E. PRES | TRUGGS FUNE TON ST. BA | RAL HOME LTIMORE, | MARYLAN | D 21213 |
| | \$ 4 A | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List on | omplications that caused that you one cause on each line. | | | | | Ap | proximate erval Between aset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | _a. ANEF | | CATURY DIST | cess Synder | MC | 2 | Hes |
| | /Medical Examiner | | resulting in dealing | Due to (or as a c | sequence of): | | | | FMA | nim |
| - (3 | | Jer | S quentially list conditions. if any, leading to immediate cause. Enter Underlying | b. Uue to (or as a c | | | | | Croe | <i>A</i> (0 |
| | nd nd transit | Examlner | Cause (Disease or injury that initiated events resulting in death) Last | · Extre | | EEMATURITY | / | | | |
| 68760, | icate be executed physician and s the burial-transit | | resulting in death) Last | Due to (or as a o | onsequence or): | | | | | |
| 687 | ficate physics the | edical | | d | | | | | | |
| .О. Вох | The law requires that the death certificate be executed ate been signed by the attending physician and age 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown | 23c. If yes, outcome of 1 ☐ Live birth 2 { 4 ☐ Pregnant at tin 9 ☐ Unknown | ☐Fetal death 3[| □Ectopic pregnancy □ Other (specify) | | 23d. | Date of delivery Month Da | y Year |
| ۵. | res that I igned by be deta | by Ph | Part II. Other significant condition | s contributing to death but | not resulting in the u | | | . Did tobacco use o | contribute to the c | ause of death? |
| rds | require been sig should b | ed b | SUSPECTE | D CHORIOA | | | | 1 ☐ Yes 2 📉N | o 3 Probably | y 4 ∐Unknown |
| of Vital Records, | e law requ has been je 2 shoul | Completed | MATERNA | XL BROUP I | 3 STREPP | COLONIZAT | 10N 24a | Was an 24 autopsy performed? | 4b. Were autopsy prior to compli death? | findings available etion of cause of |
| E E | | | MARKED | NEWBORN | ESCHYM | oses | 10 | Yes 2 No | 1 Yes 2 |] No |
| <u> </u> | Physician: Th r this certificate ral director, pag | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | 2 ☐ ER/Outpatie | Other | Place of Death (Check | | Other (Specify) | 13-1 |
| | ding Phys | $ \mathbf{F} $ | 27. Manner of Death | 28a. Date of Injury | | | | cribe how injury oc | | |
| sior | or Attanding after death. Diractor: After in by the fune | catlo | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no | ation | | M 1 Tes | | | 5.75 | |
| Division | or Attano after death Diractor: | Certification: | 3 Suicide 6 Could not determine | | r - At home, farm, st (Specify) | reet, factory, office | 281. Loca City | ition (Street and No or Town, State) | umber or Hurai H | oute Number, |
| 1 | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | ledical Ce | 29a. Certifier 1 Certifying (Check only one) | Physician: To the best of xaminer: On the basis of e | xamination and/or it | th occurred at the time, da | ate and place, and due n, death occurred at the | to the cause(s) and time, date and pla | d manner as state | d. e cause(s) |
| | o tha | Med | 29b. Signature and title of certifier | and mainter state | | 29c. License num | nber | 29d. Date si | gned (Month, Day | v, Year) |
|) | - ≤ + ō | | 1 mara Pa | News | | D004 | 46156 3.14.09 E, MARYLAND | | | |
| | | | 30. Name and address of person w | no completed cause of dea | th (Item 23a) (Type | , Print) | A | . 1 | | |
| | | | GBWC G701 31. Date filed (Month, Day, Year) | N. CHARLES | s Signature | BALTIMORE, | MARYLA | ND | | |
| - | St Regist | ate rar | MAR 2. A 2 | 009 Person | s Signature | ake | | | | |

Lively, Broy A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month 2:30 PM MARCH 19 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN MOSPITAT BALTIMORE acon 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Days Hours Min 1 □ M 2 1 F -32-1385 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits MALY BAI 1 ☐ Yes 2 Mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: MHITE 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MCDERMO EMGE, 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 M Burial 2 ☐ Cremation 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): COLITIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

Physician

/Medical

10a State

Examiner

Funeral

Director

28a-f show

Director

Funeral

<u>\$</u>

Completed

Be မ

Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.

ant: If flean Z7 Is marked ofther than "natural", or items 23a or 28a-f show my or other traumatic event, "h. Moden! Even in the northwarm. Uny or other traumatic event, "h. Moden! Even in the northwarm."

Baltimore, Maryland 21215-0036

the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit cate has been si, page 2 should b

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner ģ Be Completed Medical Certification: To

| | _ 0 | |
|---|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 9 Other (specify) | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions of | contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? |
| - ATRIAL FI | BRILLATION | 1 Yes 2 No 3 Probably 4 Unknown |
| CHRONIC OX | BSTRUCTIVE RULMONARY DISERTE | 24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No |
| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | n (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? | 28d. Describe how injury occurred |
| 3 Suicide 6 Could not be determined | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| | nysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. | |
| 29b. Signature and title of certifier | ATTENDING AYYSICIAN 29c. License number | 29d. Date signed (Month, Day, Year) |

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MARGH 19

2009

State Registrar

DHMH 17 Rev 1/2001

600D

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMARITAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** <u>5:2</u>5 a[™] 2009 23 Ρ. McDougal1 March Mary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Hampton Meadows If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb 5, 1921 If Under 1 Year Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days Months Mary land Yrs. 88 Director 218-10-9439 Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Modical Example constituted at 1 □Yes 2 □ No Director Towson Baltimore Md.10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21204 26B Dunvale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 White Completed by 3 ☐ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Solderer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret M. Hauf မ Carl E. Paulman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4111 Cremson Dr. Phoenix, Md. <u>Mrs. Kathryn Goedeke/ Daughter</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-26-09 Baltimore, Md. Holly Hill Mem Gdns 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗀 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2. No 5 Other (specify) been signed by the should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pat I. Completed by 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has incompletely filled in by the funeral director, page 2.8 autopsy perform 2 [2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one 25. Was case referred examiner? Be Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient မ 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death

Natural

Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 5 ☐ Pending Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or my estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifie of person who completely cause of death tem 2 a) (Type, Print) 515 Faimount Ave Towson, Md. 21204 Allan Shorofsky

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

MAR 2 4 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 9:30 Pm **Physician** March 21, Mary M. Marino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium Stella Maris Hospice 8. Date of Birth (Month, Day, Year) April 24,1925 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F Pennsylvania 219-16-7783 83 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinating must be notified at 1 ☐ Yes 27 No Funeral Director Essex Baltimore Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number **USA** 21221 1000 Franklin Avenue #316 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Brungo John Minacapelli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 268 Providence Circle Walkersville, Maryland 21793 Edward T. Marino, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/23/09 Baltimore, Maryland Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service dicenses
Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 **X** No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown To the Hospital or Attending Physician: The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier oneX Nurse Practitioner ner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

10

MARY MARINO

State Registrar 2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOROTHEA MAHOLLAND RSM CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2009 **Physician** James Robert Milburn, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **JAN 4, 1926** 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **1** M 2□ F Maryland 214-20-2179 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 21061 items 23a 1730 Pleasantville Drive, Apt. 2-F 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates:1943–48 1 Never Married 2 Married Specify: White 6 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) Construction Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude W. Milburn Katherine Golden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 1730 Pleasantville Drive, Apt 2-F Glen Burnie, MD 21061 Marie J. Milburn/wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc.3/23/09 Baltimore. MD 21. Signature of Funeral Service Licensee C. Todd Dring Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. Approximate Interval Between Onset and Death Heart Failure ongestive Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 years Examiner ovonary Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 □Yes 2 □No 5 ☐ Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Mellitins 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient Medical Certification: To 1 ☐ Yeş 2 ER/Outpatient 3 DOA this 27. Man er of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 041365 March 21, 2009 30. Name and address of person who completed cause of death (Item 230) (Type, Print) Hospital Drive, then Burnie, MD, 20161

State Registrar

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2. Registrar's Signalure

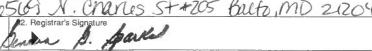
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ter /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 323 wings Date of Birth (Month, Day, **Funeral** Director ence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show of 2 should be filed within 72 hours after death with the Maryla Ith and Mental Hygjene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it a Medical Examination must be prefilled at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? eet and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐Yes No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry //Secondary (0-12) College (1-4or 5+) tronic e ch 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important; If item 27 is
any Injury or other trau 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Fire al S No 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one caus on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be execute burial-tran and Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home 2 00 Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gen 29d. Date signed (Mgnth, Day, Year) 8 200

State Registrar 31. Date filed (Month, Day, Yedr)

MAR 2 4 2009

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death Month Year

the Maryland show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Evantians out the instituted at with Pages 1 and 2 should be filed within 72 hours after death Health a item 27 of l = 5

Baltimore, Maryland 21215-0036

Box 68760.

©Division of Vital Records, P.O.

Physician /Medical **Examiner**

1. Decedent's Name (First, Middle, Last) The 2009 **Physician** 12:10 PM SARA MEZ arch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE EASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** 1 □ M 2X F Months Days Hours 06/21/1924 Director 213-20-2198 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County BALTIMORE 1 ☐ Yes 2 X No MD BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 27 STONEHENGE CIRCLE, #1A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 📉 No
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
FINKELSTEIN'S OF 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TOWSON SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ELLIS** FINKELSTEIN FANNIE KITT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 CHARTWELL CT., OWINGS MILLS, MD 21117 ELLIS MEZ / SON 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MARYCAND TRIEBEL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 03/22/2009 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if my locality to make the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑/No 24a. Was an autopsy performed 1 ☐ Yes 2 🐼 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Wother Specify 1+05PICE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: A 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide n 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 200 SMITH AVENUE SUITE 203 U6 burah 31. Date filed (Month, Day, Year) 22. Registrar's Signature State MAR 2 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Barbara Dannemiller McGarvey 3:15 P M March 19 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Carriage Hill Bethesda If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 11, 1913 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Ohio 1 □ M 2 🗙 F 95 578**-**07**-**6856 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20814 United States 4970 Battery Lane #403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aida Burchfield Robert J. Dannemiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Crocus Drive, Rockville, Maryland 20850 Barbara T. Williams/Niece 20b. Place of Disposition (Name of Arlington National Cemetery, crematory of other place) Arlington National 20a. Method of Disposition May 28, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Arlington, Virginia 4 Donation 5 Dother (Specify) 2009 22. Name and Address of Facility Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, N 21. Signature of Funeral Service Licensee Bethesda-Chevy M00198 2081 Se-35/116. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of) Coronary Artery Disease Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown

To the Hospitai or Attending Physician: The law requires that the death certificate be executed burial-tran physician the as nse for

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f shov ns 23a or 28a-f sh must be notified

'natural', or iten dical Examiner

than "

7 is marked other traumatic event, 11

Department of Health Important: If item 27 any injury or other trong once.

Physician

/Medical

Examiner

Health a

Director

Funeral

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Be Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed Be မ Medical Certification: After s after death.

il Director: A
id in by the fu

Division or Vital Records, P.O. Box 68760,

| Part II. Other significant conditions of | contributing to death but not resulting in the underlying cause given in Pa | art I. 23e. Did tobacco use contribute to the cause of death? |
|---|---|--|
| Pneumonia, Cere | ebral Infarction | 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown |
| Chronic Obstruc | ctive Pulmonary Disease | 24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ▼ No 1 ☐ Yes 2 ☐ No |
| 25. Was case referred to medical examiner? | 26. PI | ace of Death (Check only one) |
| 1 ☐ Yes 2X No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔀 | Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | | 28d. Describe how injury occurred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| 20a Cortifior 1 1 Cortifuing Bh | weising: To the heat of my knowledge, death accurred at the time, date | and place, and due to the course/s) and menney so stated |

29b. Signature and title of certifier

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number D17656 March 20, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tip Woodward, M.D. 5530 Wisconsin Ave., #550, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year)

State Registrar

MAR 2 4 2009

within 24 hours a filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 48 AM **Physician** OAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number last birthday) **Funeral** 1 M 2 X 09-08-1956 Wash. 52 Yrs 579-84-6278 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No PG Largo MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 20774 1206 Castlewood Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Federal Gov't Management Analysis 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Mary Freeman Hicks Luther ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1206 Castlewood Dr. Largo, MD 20774 Aaron D. McNair/Husband Department of Health a Important: If item 27 Is any injury or other trau once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial 3-25-09 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitiRonald Taylor II FH 21. St nature of Juneral Service License Kona 10583 Middleport Ln. White Plains, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician GPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** BACTERIAL FUNGAL CR Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 →No 3 □ Probably 4 □ Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available Be မ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed ding physician and use as the burial-tran Division of Vital Records, P.O. Box 68760 ģ nas Director: A

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

| omb | | | | | autopsy performed? 1 Yes 2 No | prior to completion of cause of death? 1 Yes 2 No | | | | | | |
|---------------|--|---|--|--|---|---|--|--|--|--|--|--|
| C | 25. Was case referred to medical | | 26. Place of Death (Check only one) | | | | | | | | | |
| To Be | examiner? 1 🗌 Yes 2 2 No | Hospital: 1 Inpatient 2 EF | ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| | 27. Manner of Death 1. Matural 5 ☐ Pending 2 ☐ Accident investigatio | (Month, Day Year) | Injury | Injury at 280 Work? 1 □ Yes 2 □ No | 28d. Describe how injury occurred | | | | | | | |
| ertification: | 3 Suicide 6 Could not be determined | | e, farm, street, factory, off | ice 28f | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | |
| edical C | 29a. Certifier 1 Certifying Pl (check only 2 Medical Exa | hysician: To the best of my knowled miner: On the basis of examination and manner stated. | edge, death occurred at the and/or investigation, in | ne time, date and place, and my opinion, death occurred | d due to the cause(s) a l at the time, date and l | and manner as stated. place, and due to the cause(s) | | | | | | |
| ₹ | 29b. Signature and title of certifier | | . 29c. Lid | ense number | 29d. Date | signed (Month, Day, Year) | | | | | | |

RES -

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JURES H

600 North Wolfe St, Baltimore, MD, 21287

31. Date filed (Month, Day, Year) MAR 2 4 2009 Registrar

29b. Signature and title of certi

Registrar's Signature parker

MD

nin 24 hours aft the Funeral Di npletely filled ir

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:45 AM March Margaret L. Nicoll /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 21, 1 Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 🗓 F 90 Yrs. 1918 Minnesota Director 214-16-6672 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment rust be negliged.

any injury or other traumatic event, the Medical Experiment is not the negliged. 1 ☐ Yes 2 ▼No Directo Gambrills Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21054 **USA** 2205 Huntfield Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Leonard James R. Lamb ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2205 Huntfield Court Gambrills, Maryland 21054 Nancy E. Nicoll, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/21/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Librates
Thomas Gregor ^{22, Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Mesough Part II. Other significant conditions contributing to death but not resulting in the underlying contributing to death but not resulting in the underlying contributions. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 10 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 116/09 1615 1 ☐ Yes 2 ☑ No death. d 2 Accident 6 ☐ Could not be 28e. Plact of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, P.O. Box 68760, n 24 hours after death.

le Funeral Director: A pletely filled in by the fu within 2.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 4 2009

and manner stated.

State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** 1.00 A M James G. Nealis Sr. 21 2009 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 11316 Red Lion Road White Marsh If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Month, Day, Year) 1929 (Country) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1⊠M 2□F 79 220-22-2648 Yrs Director Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Experiment of the motified at White MArsh 1 ☐ Yes 2 ☐ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with USA 11316 Red Lion Road 21162 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 72 hours after Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Ş Q Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Welder Beth Steel 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy Nealis Marie Bierman 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Nealis /wife 11316 Red Lion Road White Marsh MD 21162 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 3/24/09 4 Donation 5 Dother (Specify) Baltimore MD ture of Fun ral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Hos Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVASE **Physician** 6R /Medical Due to (or as a consequence of): Examiner TA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of be executed burial-tran Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) P.0. detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 🗡 0 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. ZHN or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 VNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier a) (Type, Print)
705 DIGITAL DRIVE, SUITEG UNTHOUM, MO
21090 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIAN C. RUTICUANO, 00 31. Date filed (Month, Day, Year) State Registrar

| 09-02 | | N.C. | Please Type or Print in Black Indelible Ink. Ensure All Copies Are | Legible. |
|--------|---|----------------|---|---|
| Reub | en Mucene | 1 | - For State Certificate of Death | 2009 0919 Reg. No. |
| | Physicia | an/ | Legistrar Deserodent's Name (First, Middle,Last) 2. Date of Month | Death 3. Time of Death |
| Med | ical Exami | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death | 17, 2009 1803 hrs |
| | | | 5 Winkel Court # 1A Rosedale | Baltimore County |
| | Funeral | | Trige (m) | of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) |
| | Director | | 532-31-4786 1XM 2 F 33 Yrs. 3. | 24-1976 Kenya |
| | any. | - H | Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County | 10d. Inside City Limits |
| 0 | 8 . | 5 | MD Rosedale | 1 Yes 2 6 |
| 8 | 215-0036 be filed within 72 hours after death with the Maryland half Hygiene. hed other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once. | Director | 10e. Street and Number 10f. Zip Code | 10g. Citizen of What Country? |
| 3 | ith the 23a or notifie | | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes | or No- 14. Race - American Indian, Black, |
| | or items | Funeral | 1 Never Married 2 Married Armed Forces? 1 Yes 2 No | |
| | after d | by Fi | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | specify: Black |
| | hours "natur Exam | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) | 16b. Kind of Business/Industry |
| | 336 thin 72 ne. | Completed | 4 years KN | Sinai Hospital |
| m 44 • | 21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner. | | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) | idle, Maiden Surname) |
| | 2 5 8 E 9 | To Be | 19a. Inform in it's Name/Relation but (Type: rit) 19b. Mailing Address (Street and Number or Rural Route | e Number, City or Town, State, Zip (A) |
| | e, MD 21 1 and 2 should I Health and Mer item 27 is man | | Toho Mbaki (Cousin) 11307 Democracy Lane | e Manasses VA |
| | imore, MD 2 Pages 1 and 2 shou ment of Health and N ant: If item 27 is n or other traumatic | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date of Disposition (Name of cemetery, crematory or other place) | 20c. Location - City or Town, State |
| | Baltimore, permit Pages I a Department of He Important: If ite | | 4 Donation 5 Other Specify: Hillcrast Burtal two 4 3 29 5 | 24 Kent City, Mashing |
| | Balti permit. Departm Imports injury o | | 21. Sign fure of Funeral Service Licensee | Bolto MD 21117 |
| | Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato failure. List only one cause on each line. | y arrest, shock, or heart Approximate Interval Between Onset and |
| | /Medical xaminer | 1 9 | Immediate Cause (Final disease a. Mixed drug intoxication (methadone and o | exycodone) Death |
| - | <i>)</i> | | b | |
| | | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | |
| | | xamine | (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | 7 |
| | recuted | W | d. WILDINGENDED 23a,27,28a-f,perME, g891 5/14/09 T | 'T |
| | ox 68760, sath certificate be execute attending physician and for use as the burial - trai | an/Medical | IF FEMALE: 23c. If yes, outcome of pregnancy | 23d. Date of delivery |
| | Box 68760 e death certificate b the attending physical for use as the bu | an/N | 23b. Was decedent pregnant in the past 12 months? | Month Day Year |
| | lox (eath ce attender use | sici | 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown | - |
| | tal Records, P.O. Bo cian: The law requires that the de certificate has been signed by the ector, page 2 should be detached it | , Phy | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | Did tobacco use contribute to the cause of death? |
| | S, P. | ed by | | Yes 2 No 3 Probably 4 V Unknown |
| | ords, w requir as been s s should | Completed | | Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? |
| | Rec The la icate h | E O | | Yes 2 No 1 Yes 2 No |
| | ital ician: | Be | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home | 5 Residence 6 ✔ Other: Scene |
| | Division of Vital Records, tal or Attending Physician: The law requin and alter death. an Director: After this certificate has been s led in by the funeral director, page 2 should ! | <u>:</u> ۲ | 1 ✓ Yes 2 No Impater 2 Eleventrates 3 Solventrates | scribe how injury occurred |
| | ion (tending eath. | ation | 1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 3/17/09 Fd 1803 hrs Yes 2 X No unk | |
| | Division Spital or Attend tours after death. neral Director: filled in by the f | Certification: | 20a Bloom of Injury. At home form street factory office building etc. 28f 1 000 | ation (Street and Number or Rural Route Number, City lown, State) 5 Winkel Ct 1A edale, MD |
| | ospital l hours uneral ly fillec | | 4 Homicide determined (Specify) residence Rose 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the | |
| | Division of Vital Records, P.O. Box 68760, within 24 bours after death certificate be execute within 24 bours after death. To the Funeral Direct. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. | a, date and place, and due to the cause(s) |
| | To You | Me | 29b. Signature and title of certifier 29c. License number | 29d. Date signed (Month, Day, Year) |
| | | | MM O.C.M.E. | March 18, 2009 |
| | and | | 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120 | 11 |

OCME

Registrar

State 31. Date filed (Month, Day, Year) NAR 2 4 2009

| Physicia | ın | Gwinn Fardon | , | | | | | | March 22, 2009 6:10A M | | | | |
|---|---|--|--------------------------|---|---------------|---|--|-----------------------|---------------------------------------|--------------------------|--------------------------------|------------------------------------|----------------------|
| /Medic Examin | | 4a. Facility Name (If not institution, gi | | nber) | | 4b. City, Tow | n, or Location | of Death | | | County of Deat | | .02.1 |
| Examin | er | College Manor | | ŕ | | I | utherv | ille | | | Balti | more | |
| Funeral | | | | 7. Age (In yrs. | | Months Da | | r 24 Hrs. Min. | 8. Date of Bir Month, Da June 1 | th (½ Year) | 9. Birt | hplace (State o | or Foreign |
| Director | | 072-14-4069 | 1A_IM 2LIF | | 87 Yrs | | | | June 1 | 6, 19 | 921 E | ngland | |
| and w | 1 | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or | Location | | | | | | 10d. Inside Ci | ty Limits |
| Maryli f sho | | Maryland Baltin | nore | | Ruxto | on | | | | | | 1 □ Yes | 2 🏹 No |
| 10 the 1 | rec | 10e. Street and Number | | | | 10f. Zip Coo | de | | | 10g. Citiz | zen of What Co | untry? | |
| 23a o | at D | 1411 Locust Avenu | Je | | | 2 | 21204 USA | | | | | | |
| ems a | Funeral Director | 11. Marital Status | 12. Was Dece Armed Fo | edent Ever in U. | .s. 1 | 3. Was Decedent If Yes, specify (| of Hispanic C | rigin? (Spean, Puerto | ecify Yes or No Rican, etc.) | - 1 | 14. Race - Ame Black, White | | |
| or it | by Fu | 1 Never Married Married | 1X Yes | 2□No 19 ve 10 | 42 | | 1 □Yes 2♥ No Specify: Specify: | | | | | | |
| hours tural" | ed b | | | | | | | | | | nd of Business/ | Industry | |
| in 72 n "na n "na | (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) | | | | | | | | | | | , | |
| y with giene | E O | Elementary/Secondary (0-12) | malist Ne | | | | | per | | | | | |
| al Hy I othe | 17. Father's Name (First, Middle, Last) | | | | | | | | (First, Middle | | Surname) | | |
| Ment Ment arkec aric e | ဥ | Hamilton Owens Olga Voli E | | | | | | | | | | | |
| 2 sho | | 19a, Informant's Name/Relationship | | | | Town, State, 2 | | | | | | | |
| l and Health Sm 27 ther t | - | Laura Templeton 20a. Method of Disposition | n, Daugn | | | 11 Locust | | | Date | | cation - City or | | |
| ages int of t: If ite | | 1 ☐ Burial 2 ☐ Cremation 3 l | | State | | sposition (Name of crematory or other | | 03/2 | | | timore, | | and |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at once. | | 4 □ Donation 5 □ Other (Spec | | Met | .FO C. | rematory 22. Name and A | | | | | | | |
| mpe any once | | 21. Signature of Funeral Service Lice Thomas Gregori | Ly | | | Crematic 299 Fred | on Soci derick | Road | or Mary Baltim | land, | , inc. Maryla | nd 2122 | 28 |
| | | 23a, Part 1, Enter the disease, or con | mplications that c | aused the deat | th. Do not | | | | | | | Approximat Interval Bet | е |
| Physician | | shock, or heart failure. List onl | y one cause on e | ach line. | ~~ | & C | me | 21 | | | | Onset and | Death Cs |
| /Medical | | disease or condition resulting in death) | a Due to | (or as a conseq | uence of): | | | | | | | ,,,,,, | 1000 |
| Examiner | | Sequentially list conditions | b | | | | | | | | | | |
| oit od | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events. | Due to | (or as a conseq | uence of): | | | | | | | | |
| xecute and I-trans | xam | that initiated events resulting in death) Last | c | (or as a conseq | uence of): | | | | | | | | |
| death certificate be executed e attending physician and d for use as the burial-transit | | | | (=- === =============================== | , , . | | | | | | | | |
| eath certificate be executed attending physician and for use as the burial-transit | Physician/Medical | | a | | | | | | | | | | |
| h cert endin use (| In/M | IF FEMALE: 23b. Was decedent pregnant | | tcome of pregna | | 3 ☐ Ectonic pregu | nancy | | | 2 | 23d. Date of del | | |
| s deat | sicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | | nant at time of | | | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | | | | Day | Year |
| sician: The law requires that the dicertificate has been signed by the rector, page 2 should be detached | Phy | 9 Unknown | | | Ikin n in Ab | | e siuse in Dos | 4.1 | 220 Did | tobacco III | se contribute to | the cause of o | Neath? |
| The law requires that the ate has been signed by the page 2 should be detached. | þ | Part II. Other significant conditions | contributing to a | eath but not res | sulting in tr | ie underlying caus | e given in Par | l I. | 1 🗆 | | / | robably 4 | |
| requi | Completed | | | | | | | | | | | | |
| elaw hasl | mp[| | | _ | | | | | 24a. Was auto | | prior to death? | utopsy findings completion of c | available ause of |
| n: Th ficate r, pag | | 25. Was case referred to medical | | | | | 00 DI- | (D | 1 □ Yes | 2 🗹 No | 1 □Yes | 2 □ No | |
| or Attending Physician: The Ifter death. Director: After this certificate him by the funeral director, page | э Ве | examiner? 1 Yes 2 No | Hospital: | Inpatient 2 | 1 FB/Outp: | atient 3 DOA | Othor: | | h (Check only | | Other (Spe | ASSIST | edZni |
| g Phy er this eral c | n: To | 27. Manner of Death | 28a. Date | | 28b. Tim | | Injury at Work? | | 28d. Describe | | | M | citit, |
| ath. rr: Aft | atio | 1 Natural 5 ☐ Pending 2 ☐ Accident investigati | ion | iii, Day, Iear) | linju | M | 1 ☐ Yes 2 | □No | | | | | |
| r Atte er de recto | Certification: | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | Zoe. Flace | e of Injury - At h ing, etc. (Speci | ome, farm | , street, factory, of | fice | | | Street and wn, State) | d Number or Ri | ural Route Nun | nber, |
| ital o irs afi ral Di lled ir | | | | | | | | | | | | | _ |
| To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fun | Medical | | aminer: On the b | | | death occurred at t or investigation, in | | | | | | | s) |
| o the | Mec | 29b. Signature and title of certifier | and man | mer stated. | | 29c. Li | cense numbe | r | | 29d. Date | e signed (Mont | h, Day, Year) | |
| ⊢ ≶ ⊢ Õ | | MA A | ~ 1 | 1. C. | - L | no i | 775 | 205 | - | MI | will | 23 | 009 |
| nx1 | | 30. Name and address of person wh | no completed cau | se of death (Iter | 23a) (Ty | pe, Print) | 12 | 0 | C | 1 | to. a | 3 | 2 |
| 10, | | W. A. R. Ley | GAM | (E | 701 | N- 0 | char | Kes. | لا . + ل | bal | 10.00 | 6 20 | COR |
| Sta | | 31. Date filed (Month, Day, Year) NAR 2 4 200 | 9 Senes | Registrar's Si | ature | we | | | | | | | |
| Reaistr | ar - | [[[[]]]] [[] [] [] [] [] [| - / | ~ | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** O3 08:52 ам 0siecki В. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Gilchrist Care Center Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** 03/30/1923 Months Days Hours Min. 1 □ M 2 🛛 F MaryTand 85 215-16-9918 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 3011 1/2 3rd Avenue U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 📉 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanislawa Gurocka Casimir Lupo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and Department of Health an Important: If item 27 is any Injury or other trau 9825 Harford Road, Parkville, MD 21234 Jean Pugh, Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State 03/26/2009 Baltimore, Maryland Sacred Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Carpropell 5305 Harford Road, Baltimore, MD 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ·LoT· Other: 4 I Nursing Home 5 Residence 6 Other (Specify) Wospul 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

8521

32. Registrar's Sanatu

1 - For State Registrar

Certificate of Death

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for a

Physician/Medical

Completed by

Be

Certification: To

Medical

State Registrar

Division of Vital Records, P.O. Box 68760,

| 1. Decedent's Name (First, Middle, Last) | | | | | | | | | | | 2. Date of Death | | | | Death |
|--|---|--|---|---|--|---|--|--|--|---|--|--------------------------|--|---|--|
| JOSEPH CH | LARLES | ORLOWSKI | | | | | | | | MARCH | 21 | , 200 | 9 Year | 10:30 |) A M |
| 4a. Facility Name (If | not institutio | n, give street and nι | ımber) | | | 4b. City, | Town, or | Location | of Death | | | 4c. County | y of Death | | |
| 3800 WHIT | E AVE | | | | | BA | LTIMO | ORE | | | İ | N/A | | | |
| 5. Social Security No | umber | 6. Sex | 7. Age | (In yrs. I | ast birthday) | | If Under 1 Year If Under 24 Hrs. 8. Date of Birth | | | | | 9. Birthp | lace (State o | or Foreign | |
| 218-28-15 | 28 | 1 M 2 L F | 77 | | Yrs. | WOITING | Days | riouis | IVIII I. | MAY 1. | $5^{"}, 1$ | .931 | N | EW JEH | RSEY |
| Usual Residence of | Decedent | | | | | | | | | | | | | | |
| 10a. State | 10b. County | | | 10c. City, Town or Location | | | | | | | | 1 | | - | |
| MD | N/A | Δ | | BALTIMORE | | | | | 1√ Yes 2 □ | | | | 2 🗌 No | | |
| 10e. Street and Nun | nber | | | | | 10f. Zip Code | | | | | 10g. Citizen of What Country? | | | | |
| 3800 WHITE AVE | | | | | | 21206 | | | | | | USA | | | |
| 11. Marital Status 12. Was Decedent Ev Armed Forces? | | | | | S. 13. | Was Dece If Yes, spe | dent of H cify Cuba | ispanic Or ın, Mexica | rigin? (Sp n, Puerto | ecify Yes or N Rican, etc.) | 0- | | | | |
| | | 2 □ N ive Dates: | lo | | | | | | | fy: WHI | | | | | |
| (Specify only highest grade completed) I (G | | | | | | | edent's Usual Occupation | | | | | ib. Kind of B | lusiness/Inc | lustry | |
| | | | | +) | life. | DO NOT u | se retired | iunng mos I) | St Of WORK | ing | ľ | | | | |
| 12 | , (5 1-5) | | | ., | AIR | COND | MILIOITI | N MEC | HANI | С | | SELF- | EMPLO | YEED | |
| MD N/A BALTIMORE 10e. Street and Number 3800 WHITE AVE 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married 1 □ Never Married 2 □ Never Married | | | | | | | | | | ne) | | | | | |
| ANTHONY ORLOWSKI | | | | | | | | VIR | GINI. | A TISCI | H | | | | |
| 19a. Informant's Name/Relationship (Type. Print) 19b. N | | | | | | | | | | | | | | Code) | |
| CATHERINE LEPORE-COMPANION | | | | | | | 800 WHITE AVE BA | | | | ALTIMORE, MD 21206 | | | | |
| | | | | 20b. P | ace of Disposition (Name of | | | | | Date 20c. Location - City or Town, Sta | | | wn, State | | |
| | | | State | | | | | | | /09 | В | BALTIM | ORE, | MD | |
| 21. Signature of Fu | neral Service | Licensee | | | 2: | 2. Name a | nd Addres | ss of Facili | ity MI | LLER-D | ĺРР | EL FU | NERAL | HOME, | , INC |
| Make | 16 in | W) | | | | 6415 | BELA | AIR R | D | BAL' | ΓIM | ORE, | MD 21 | 206 | |
| 23a. Part : Enter th | ne Isease, or | | | | | | | | | | arres | t, | | Approximat Interval Bet | e ween |
| Immediate Cause (| Final | C | 200 | +1110 | o Ho | art | Fa. | lure | , | | | | | Onset and | Death |
| resulting in death) | n | a. Due to | in as | consequ | ience of). | | 1 001 | 1011 | | | | | - | ge ar | |
| | | Ca | C 5. | 000 | - 00 | T.05 | 6 0 | 1150 | as | 0 | | | | 40 or | 15 |
| Sequentially list cor | nditions, | b. Due to | for as | CONSCIO | ence of): | 141 | 70 | (100 | | | | | | / | |
| cause. Enter Under Cause (Disease or | rlying | | (| | | | | | | | | | | | |
| that initiated events | | c Due to | (or as | a consequ | uence of): | | | | | | | | | | |
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23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death?

Day

Year

23d. Date of delivery

Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 🗌 No 3 Probably 4 Unknown 24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 □Yes 26. Place of Death (Check only one)

5 Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

25. Was case referred to medical examiner? Hospital: 1 Yes 2 No 27. Manner of Death

2 No

9 Unknown

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 \sum Nursing Home 28c. Injury at Work?

1 □ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie

and manner stated.

D44717

29d. Date signed (Month, Day, Year) March 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7801 York Rd, Suite CarolNewill

31. Date filed (Month, Day, Year)

224, Towson, Maryland 21204 bares

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8890 4-8-09 vt
State of Maryland / Department of Health and Mental Hygiene 2 1 9
Amend Items 7,8 per In, 8828, 12, 22, 109 dbb
Certificate of Death
Reg. No. 09198 1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Sitadevi Pate1 March 21, 2009 2:00 P.M. Sitdevi Patel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 4310 Bedrock Circle Apt. 103 Perry Hall If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) India 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗓 F 93 94 Yrs July 10,1915 Unk. Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 21236 Great Britain 4310 Bedrock Circle Apt. 103 Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: Asian, Indian Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nama Patel Kuvar Patel မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Negin Patel / Son 4310 Bedrock Circle, Perry Hall, Maryland 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Evans Function (Name of Place)

Evans Function (Name of Place)

Bel Air permit. Pages Department of Important: If Its any Injury or o ó 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/24/2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Evans runeral chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) WITE /Medical (or as a consequence of) Examiner S uential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OMBOLYTO PENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1□ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕱 Residence 6 ☐ Other (Specify) 2 this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Il Director: A 2 Accident death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 2 4 2009

TASNEEM

mi

2835

ranker

mi

Registrar's Signature

29c. License number

28195

Smith AVE,

29d. Date signed (Month, Day, Year)

SUITE 283

MI)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKHANI

| | | For | State of Marylan | | | | ental Hygi | ene a a a | 0 00100 |
|--|---------------|--|--|------------------------|--|---------------------------|---|-----------------------|---|
| | | 1 - State Registrar | | Cei | rtificate of Dea | | | g. No. 2 U U | 13 69193 |
| Physi /Med | | 1. Decedent's Name (First, Middle, | Pines | 3 | | | 2. Date of Death Month MaseM | | ar 3. Time of Death |
| Exam | | 4a. Facility Name (If not institution, Maryland Gelege 5. Social Security Number 6. | eral Hospital | | 4b. City, Town, or Loca Baltimore If Under 1 Year If U | Crty | | 4c. County of E | |
| Funera Directo | | 230-30-4737 Usual Residence of Decedent | 3. Sex 1 ☐ M 2 🗹 F 7. Age (In yrs. | Yrs. | | nder 24 Hrs. burs Min. | 8. Date of Birth (Month, Day, O2 • 24 | Year) • 1930 | Birthplace (State or Foreign Country) |
| ryland how | | 10a. State 10b. County | | ty, Town or Lo | | | | | 10d. Inside City Limits |
| he Ma | Director | MD | TO TO | Himo | re | | | | 1 ☑Yes 2 ☐ No |
| 3a or | į | 1701 Eutaw | Place Apt. 11 | 2 | 10f. Zip Code | | 10 | g. Citizen of What | : Country? |
| ems 2 | Funeral | 11. Marital Status | 12. Was Decedent Ever in U. Armed Forces? | | Was Decedent of Hispani f Yes, specify Cuban, Me | ic Origin? (Spec | cify Yes or No- | | American Indian, |
| ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland sf Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninar Frust by a tilled. | \$ | 3 Widowed 4 □ Divorced | | | _ | ecify; | ilican, etc.) | Specify: | hite, etc. |
| 15-1 | lete | 15. Decedent's (Specify only highest | Education grade completed) | 16a. Deced | dent's Usual Occupation kind of work done during DO NOT use retired) | most of working | g 11 | 6b. Kind of Busine | ess/Industry |
| 2121 d within giene. | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | Don | restic | | | Peirate | |
| tnd be file sta Hy d othe | Be | 17. Father's Name (First, Middle, La | st) Unk | | | | (First, Middle, Ma | , | |
| Maryland d 2 should be file th and Mental Hy 77 Is marked othe | 2 | 19a. Informan <u>t's</u> Name/Relationship | (Type Print) | 10h Mailin | g Address (Street and N | | edding | | In Tin Ondal |
| Mith 9 | | Fave Pines | (Daughter) | 1 4 4 | Northbour | | | male N | D 21239 |
| | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 | O 20b. P | | sition (Name of natory or other place) | Da | | c. Location - City | or Town, State |
| Baitimo permit. Page Department of Important: If any injury of the page of the | | 4 □ Donation 5 □ Other (Spe 21. Signatur Funeral Service Lice | cify) G | on Mo | unt Cemeter | y 3.24 | ·04 E | attimoe | e, MD. |
| Departi Importi any inj | | Valadim (| O. Steene | 5 | Name and Address of P | mas Kl | n C. Gue | (212 | al Services |
| | | 23a. Part 1. Enter the disease, or co shock, or heart failure. List on | implications that caused the death | h. Do not ente | er the mode of dying, suc | ch as cardiac or | respiratory arres | it, | Approximate Interval Between |
| Physician /Medica | | Immediate Cause (Final disease or condition resulting in death) | a archeros | dero | the Carlio | vescul | or dis | ease | Onset and Death |
| Examine | • | , | Due to (or as a consequ | uence of): | | | | | |
| od sit | ine. | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ | uence of): | | | | | |
| xecute al-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a consequ | uence of): | | | - | | |
| ificate be executed physician and the burial-transit | edical E | | d | | | | | | |
| ertifica | | IF FEMALE: | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown | Ideath 3□ | Ectopic pregnancy Other (specify) | | | 23d. Date of Month | delivery Day Year |
| s that t ned by | by Ph | Part II. Other significant conditions | contributing to death but not resu | ulting in the un | derlying cause given in P | Part I. | 23e. Did toba | cco use contribute | e to the cause of death? |
| ecords, law requires t as been signe 2 should be c | led b | · Hynesten tion | 7 | | | | 1 □ Yes | 2 □ No 3 □ | Probably 4 Unknown |
| e law r has be e 2 sh | Completed | Dianells | nellilus | | | | 24a. Was an autopsy | prior | autopsy findings available to completion of cause of |
| VICAL FICIAL: The certificate ector, pag | e Co | 25. Was case referred to medical | T | | | | performe 1 🗆 Yes 2 🗓 | d? death ⊒No 1□Y | n? ′es 2 □ No |
| ysicia nysicia nis cert | To Be | examiner? | Hospital: 1 ☐ Inpatient 2 ☐ | ÉR/Outpatien | | | <i>Check only one)</i> e 5∏ Residen | ce 6 □Other (S | Specify) |
| Ing Pl | | 27. Manner of Death 1.☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? | 28 | d. Describe how | injury occurred | poonly, |
| Attending Phy ar death. ector: After this by the funeral d | ertification: | 2 Accident investigati 3 Suicide 6 Could not | be Occ. Disposed in the law of th | me, farm, stre | M 1 ☐ Yes 2 | | f Location (Stre | et and Number or | Rural Route Number, |
| tal or safter al Dire | Certi | 4 ☐ Homicide determine | building, etc. '(Specify | () | -,, | | City or Town, | State) | nural noute Number, |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: | Medical (| 29a. Certifier 1 ← Certifying I (Check only one) 2 | Physician: To the best of my know aminer: On the basis of examinat and manner stated. | tion and/or inv | actigation in my aninian | بفصام محمثة مطقفصا | | dria 4a 4ba (-) | |
| To the within com | Ž | 29b. Signature and title of certifier | N O | | 29c. License numb | per | 290 | . Date signed (Mo | onth, Day, Year) |
| , | | My mus | | | 10039 | 1/27 | | 3/22/ | 2009 |
| d d | | 30. Name and address of person wh | | 23a) (Type, F | law st. | Bulte | more | MDZ | 1201 |
| St Regist | ate trar | 31. Date filed (Month, Day, Year) | 109 Perus E | h. ba | Mad | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8 19b perFH 6889 3/24/09 WS
State of Maryland Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year AM M **Physician** Pressman 500 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Convaluscent & Nursing Home Baltimore 21208 MD Count Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. **Funeral** 217-24-0487 MD Director Usua! Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If then 27 is marked other than "natural", or items 29a or 28a-f show inly not other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7920 SCOTTS LEVEL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 □ Yes 2 🕅 No WHITE Baltimore, Maryland 21215-0036 Specify Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SANITATION CITY OF BALTIMORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **PRESSMAN** MAX BESSIE ၉ SCHILLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelleydale 19a. Informant's Name/Relationship (Type. Print) SHELLYDALE DRIVE, BALTIMORE, MD MARSHA SOBER / NIECE 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State BETH JACOB CONG. 03/22/2009 FINKSBURG, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ma /Medical Due to (or as a conse uence of) Examiner Sequentially list conditions, it among to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be def Completed by 2 **(**No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide within 24 hours after dea To the Funeral Directo completely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1448 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7920 SCOTTS LEVEL ROAD, PIKESVILLE, MD SUNIL RAJANI, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 4 2009 Registrar

| | | | For State Registrar | State of Ma | aryland | | rtment of F tificate of | | Mental Hy | /giene Reg. No | 2009 | 09201 | |
|--|--|--|--|--|---------------|--------------------------------|--|--|--|------------------------|---|---|--|
| Ph | ysicia | ın | 1. Decedent's Name (First, Middle, La | , | | | | - | 2. Date of De Month | eath Da | ay Year | 3. Time of Death | |
| | Medic | | Sachindra Nath | | | | | | March | 2. | | 11:15 A M | |
| <i>)</i> Ex | camin | er | 4a. Facility Name (If not institution, given 9700 Grenadier (| · | | | 4b. City, Town, o Beth | | itn | 40 | County of Death Montgome | | |
| Fur | neral | | 5. Social Security Number 6. 5 | Sex 7. Ag | e (In yrs. la | st birthday) | If Under 1 Year | If Under 24 Hr | | rth | 9. Birth | place (State or Foreign | |
| | ector | | 217-34-9373 | 1 ⊠ M 2□F | 89 | Yrs. | Months Days | Hours Mir | April | 3, rear) | 919 | India | |
| pu | | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | Town or Loc | ation | | | | | 10d. Inside City Limits | |
| /aryla | E P | ō | Maryland Montgo | .m.o.1877 | | hesda | Janon | | | | | 1 □ Yes 2 No | |
| the l | THE STATE OF | Director | 10e. Street and Number | шегу | рес | liesua | 10f. Zip Code | | | 10g. Ci | itizen of What Cou | ntry? | |
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| r deat | | Funeral | 11. Marital Status | 12. Was Decedent I Armed Forces? | Ever in U.S | i. 13. V | Vas Decedent of F Yes, specify Cub | lispanic Origin? (an, Mexican, Pue | Specify Yes or Norto Rican, etc.) | 0- | 14. Race - Ameri Black, White, | | |
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| r y ich | natic | 욘 | Bhuth Nath Pradhan Ahallya Pradhan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig | | | | | | | | | | |
| INICA Id 2 si Ith an 27 is 1 | tran | | Sikta Pradhan/W | | | | • | | | | Maryland | , | |
| star of Hea | othe | | 20a. Method of Disposition | | 20b. Pla | | sition (Name of natory or other place | | Date | | ocation - City or T | | |
| Page nent c | ıry or | | 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia | Removal from State (fy) | | | rematorium | i na | rch 23, 2009 | Ве | ethesda, | Maryland | |
| Daililliore, IMaryiariu ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If len 27 is marked other than "natural" or items 23a or 28a-f show | any inju once. | | 21. Signature of Funeral Service Lices | nsed + | M0154 | 22 R | Name and Addre | ss of Facility Imphrey Fu | neral Home Bethesda | e/Beth | - | Chase, Inc. | |
| | | | 23a. Part Enter the disease, or com shock, or heart failure. List only | plications that caused | the death. | | | | | | | Approximate Interval Between | |
| Physic | cian | | Immediate Cause (Final disease or condition | Arrhyth | | | | | | | | Onset and Death | |
| /Med Exam | | | resulting in death) | Due to (or as | | , | | | | | | | |
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| U, exec | rial-tra | Exa | that initiated events resulting in death) Last | Due to (or as | | | . regrai | abeurur | cerden | | | TO TEGIE | |
| OI VILAI NECOLUS, R.O. BOX 80/00, Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and | s the burial-transit | dical | | d | | | | | | | | | |
| ertific | | | IF FEMALE: | 00- 14 | | | | | | | | | |
| DOX eath cer attendir | for us | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1 Live birth 4 Pregnant a | 2 Fetal | death 3 □ | Ectopic pregnand Other (specify) | у | | | 23d. Date of delive Month | very Day Year | |
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| law re | 2 sho | Completed | | | | | | | 24a. Was | nsv | prior to co | opsy findings available ompletion of cause of | |
| The | page | Con | | | | | | | perf 1 □ Yes | ormed? 2 X No | death? 1 ☐ Yes | | |
| VILAI iician: T certifical | rector, | Be | 25. Was case referred to medical examiner? | Hospital: | | | Oth | | eath (Check only | | | | |
| Phys c | funeral director, page 2 should be detached | 임 | 1 ☐ Yes 2 🛣 No 27. Manner of Death | 28a. Date of Inju | iry : | R/Outpatien 28b. Time of | t 3 DOA | v at | Home 5 X Res | | 6 ☐ Other (Speci | ffy) | |
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| lor Attending after death. Director; Afte | d in by th | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Suicide 4 Homicide 28d. Describe how injury occurred | | | | | | | | | | | |
| To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After the | letely fille | Medical C | 29a. Certifier 1 Certifying Pl (Check only one) | hysician: To the best of miner: On the basis of and manner sta | f examinati | /ledge, death on and/or inv | occurred at the ti restigation, in my o | me, date and pla prinion, death occ | ce, and due to the curred at the time | e cause(s , date an | s) and manner as id place, and due t | stated. to the cause(s) | |
| To th To th | comp | Me | 29b. Signature and title of certifier | | | | 29c. Licens | e number | | 29d. Da | ate signed (Month, | Day, Year) | |
| | | |) In | | 2 | | D35 | 579 | | Ma | rch 22, | 2009 | |
| | | | 30. Name and address of person who | | | | | | 205 = | | | 1 00011 | |
| | 24-2 | | Susan J. Miller, 31. Date filed (Month, Day, Year) | 30 Pogietr | or's Cianati | Iro. | | Suite | 305, Bet | nesd | a, Maryl | and 20814 | |
| Re | Stat egistra | | MAR 2 4 200 | - 16 . | A. | Bons | Less . | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Jacqueline Renee Quinn 2009 19 6:30A M March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Tate Hospice House of the Chesapeake Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 1 F Days Hours Min 217-56-3598 53 1956 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "control Event or other event or other traumatic event, the "control Event or other event 1 ☐ Yes 2 No Director MD Anne Arundel Linthicum 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 421 W. Maple Road 21090 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 Tes 2 Tes 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) Banker Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Alexander Quinn Shirley Maitland Meek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr Fred Phelps / Husband 421 W. Maple Road Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March Glen Haven Mem. Park 2009 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Servcies PA 1 2nd Ave.SW Glen Burnie, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** mont disease or condition resulting in death) /Medical Due to (or as a consequence o) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE use yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death Was deceus.
in the past 12 money

Ves 2 No 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No 1 TYes the Hospital or Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Cherapecke Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSING HOUSE 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Day, Year) after death. 27. Manner of Deat 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

State

Registrar

29b. Signature and little of certifier

0) 31. Date filed (Month, Day, Year) MAR 2 4 2009

32/Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year S: ISP M MARCH KUNINSON 2609 ಳಲ 4c. County of Death Facility Name (If not institution, give street and number) City, Town, or Location of Death evination 8. Date of Birth (Month, Day, Year) 8 · 13 · 1935 (In yrs. last birthday) Birthplace (State or Foreign Country) 7. Age Hours Min. 1 M 2□F Months Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location State 10b. County 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code Street and Number Gallewood St. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🗷 No 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 7. Father's Name (First, Middle *CODINSON* 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relati (Type. Print) (SON) Shamrock Ave. KODINSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Methed of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Battimole. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility re of Funeral Service Citensee Baltimore Nat stell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or a la consequence of): DAY disease or condition resulting in death) Heart 1) Longestire Due to for as a conse 2040 Hyponlansian Due to (or as aconsequence of): Joulune Renel hrenic 4 45 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician: -/Metical **Examiner**

burial-tran

attending physician for use as the buria

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Completed

Be

Certification: To

Medical

funeral director, page 2 s

filled in by the

24 hours after death.

within 24 hor To the Fune

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

\$

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, it a Medical Experiment must be notified at

d 2 should be filed within 7; Ith and Mental Hygiene. 7 is marked other than "n

Baltimore, Maryland 21215-0036

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

mellipus

24a. Was an

autopsy performed Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death 1 D Natural

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

D30494 K D LSHIND

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 3/23/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Robert Mon 716 Maidan Chore

Hospital:

maidan choice

and manner stated.

lane catonrile mostille

State Registrar

\ Q

MAR 2 4 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G893 7/28/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9:10 A M 20 2009 Ann Taylor Raley March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Munroe Court Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/29/1934 5. Social Securit 6804 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🕱 F 218-32-1934 74 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the flexibilities at 1 Yes 2 No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Court 21401 U.S.A. 34 Munroe Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after of Hygiene.
Hygiene. □Yes 2**X** No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Researcher Real Estate th and Mental Hygien
7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard M. Taylor Dorothy Wannenwetsch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health an permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr Captains Point Lane, Hollywood, MD 20636 John Cook/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 3/23/2009 4 Donation 5 ☐ Other (Specify) Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Ligensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -Una mustus Cancer disease or condition resulting in death) /Medical Due to (or as sonsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ed by the detached f 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes icate has been signated by page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 TYes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cernen wer march 20,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AP GUL Registrar's Signa , 900, Beston & Road # 300, Annapolis, MD 21401 Wern 31. Date filed (Month, Day, Year) MAR 2 4 2009 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Herbert Linwood Ritter March 22 2009 12:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 10609 Vincent Road White Marsh Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 29, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 84 Yrs. 219-14-2001 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examirer must be rictified at 1 ☐ Yes 2 No Director Baltimore White Marsh Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21162 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. USA 10609 Vincent Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1943 If Yes, Give Year or Dates: 1949 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No Specify White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Millwright Steel 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Jessie McAllister ည William Howard Ritter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Day, Niece 10609 Vincent Road White Marsh, Maryland 21162 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23/09 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee
Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 □Yes 2 🗖 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

41

DHMH 17 Rev 1/2001

State

Registrar

(Check only one)

31. Date filed

29b. Signature and title of certifier

and manner stated.

Rd 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

| | | | | partment of Health and Nertificate of Death | | iene _{g. No} 2009 | 09206 | | |
|--|---|----------------|--|---|--------------------------------------|--|--|--|--|
| | Dharia | | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | n | 3. Time of Death | | |
| | Physici /Medio | | Marcel H. Ross | | March | 19 2009 | 11:52A M | | |
| | Examir | er | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | | | |
| | Funeral | | Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthde | Annapolis y) If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Anne Aru | andel | | |
| | Director | | 217-46-4923 1 M 2 F 61 Yrs. | Months Days Hours Min. | Month, Day, | rear) Coun | rland | | |
| 100 | > | | Usual Residence of Decedent | | | | | | |
| arva e | shov | ō | 10a. State 10b. County 10c. City, Town or | | | 10 | Od. Inside City Limits | | |
| the N | 28a- | Director | Maryland Anne Arundel Glen 10e. Street and Number | Burnie | 10 | Og. Citizen of What Count | 1 ☐ Yes 2 ₹ No | | |
| with | 3a or | | 8057 Greenleaf Terrace Apt 21 | 21061 | " | | ny: | | |
| death | ams 2 | Funeral | | 3. Was Decedent of Hispanic Origin? (Sp | ecify Yes or No- | USA 14. Race - America | an Indian, | | |
| 36 after | or it | | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No | If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: | Rican, etc.) | Black, White, e | | | |
| 5-0036 72 hours after death with the Maryland | tural | Completed by | 3 LI Widowed 4 LYDivorced Year or Dates: | | | Specify: Bla | | | |
| 21215-0036 d within 72 hours aft | n "na Nedic | plet | (Specify only highest grade completed) (Gi | edent's Usual Occupation re kind of work done during most of work . DO NOT use retired) | ing 1 | 6b. Kind of Business/Ind | ustry | | |
| d 2121 | giene er tha , the | Som | Elementary/Secondary (0-12) | nsignment Shop | | Self Empl | oved | | |
| and be file | d oth | Be | 17. Father's Name (First, Middle, Last) | | e (First, Middle, M. | | | | |
| Maryland d 2 should be file | d Mer narke natic | 은 | Alfred G. Holland | | Lee Wat | | | | |
| , Ma | Ith and 27 is ma | | TOTMET | ling Address (Street and Number or Rur | | | • | | |
| . 6, | if of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic event, the Medical Exercity or other traumatic events. | | Charles W. Ross Sr(Spouse) 336 20a. Method of Disposition 20b. Place of Dis | 3 Thomas Point F position (Name of ematory or other place) | | apolis, Md Oc. Location - City or Toy | | | |
| altimore, rmit. Pages 1 ar | nent c int; if | 110 | TE Dana 2 Command 3 Chemova nom State | | 1_09 | Baltimore, | ма | | |
| Salti ermit. | Department of Heal Important: If Item 2 any injury or other once. | | | Wm ^{Name} Redess of Eacilisons | | | riu . | | |
| <u> </u> | . 6 5 ± ∆. | 01 | garry & Rees Mo0483 | 821 West St. Ann | apolis, | , Md. 2140 | 1 | | |
| 4 | | | 23a. Part1. Enter the disease, of complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. | nter the mode of dying, such as cardiac | or respiratory arres | | Approximate Approximate Detween | | |
| | iysician Medical | | Immediate Cause (Final disease or condition resulting in death) | ren Organ ta | ilue | | Onset and Death | | |
| | caminer | | Due to (or as a conseque (a): | Acres De La Marchel | Ano. | . /sn_ | | | |
| - X | | ner | Sequentially list conditions, if any, leading to immediate Due to (or as consequence of): | Tree of the second | Charle | | | | |
| ecuted | ind transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | |
| 8760, cate be executed | sician and burial-transit | | resulting in death) Last Due to (or as a consequence of): | | | | | | |
| 68760 , ificate be e | phy: | dical | d | An an at a second a | | | | | |
| Box 6 | attending p for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | 23d. Date of deliver | | | |
| deat deat | e atte | icia | in the past 12 months? 1 Live birth 2 Live beath 3 | ☐ Ectopic pregnancy ☐ Other (specify) | | | y Day Year | | |
| P.O | by the | hys | 9 Unknown | | | | | | |
| Records, P.O The law requires that the | igne be c | by | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | icco use contribute to the | | | |
| Social | s been s should | eted | | | 1 Yes | 2 No 3 Proba | bly 4 Unknown | | |
| Records, ne law requires th | has le 2 | Completed | | | 24a. Was an autopsy performe | prior to com | sy findings available pletion of cause of | | |
| | certificate h ector, page | | 25. Was case referred to medical | | 1 □ Yes 2 [| INO 1 ☐ Yes 2 | No | | |
| 03 | co = | To Be | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient | 26. Place of Death | | ce 6 ☐ Other (Specify) | | | |
| о е В | | Ľ: | 27. Manner 1 eath 1 eath 28a. Date of Injury (Month, Day, Year) 28b. Time Injury | | 28d. Describe how | | | | |
| /ISION Attending | feath. tor: A the fu | catic | 2 Accident investigation 3 Suicide 6 Could not be | M 1 □Yes 2 □No | | | | | |
| = b | Direction by in by | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify) | reet, factory, office | 28f. Location (Stre City or Town, | et and Number or Rural I State) | Route Number, | | |
| Spital | 24 hours after death, Funeral Director: / etely filled in by the f | - 1 | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea | th occurred at the time, date and place | and due to the cau | ise(s) and manner as sta | tod | | |
| He Ho | within 24 hours afte | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. | nvestigation, in my opinion, death occurr | ed at the time, date | e and place, and due to t | he cause(s) | | |
| ٦ <u>١</u> | To the | Ž | 29b. Signature and title of certifier | 29c. License number | 290 | 1. Date signed (Month, Da | ay, Year) | | |
| | | 1 | | D00058297 | | 3/19/200 | 9 | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type | 0 11 11 11 | 10.1 | And | CAMP | | |
| | Stat | e_ | 31. Date filed (Month, Day, Year) 2009 12 Registrar's Signatury | | م حرم | · wincip | VSV*(I) | | |
| | Registra | | MAK & 4 2009 Chans B. A | are | | | | | |

Physician /Medical Examiner Physician/Medical Examiner

Physician

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Director

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Director

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invided Examinating to notify of a once.

Baltimore, Maryland 21215-0036

death with the Maryland

funeral within 24 hours To the Funeral

Division of Vital Records, P.O. Box 68760

| niner | Sequentially list conditions, if any, leading to immediate | b | | | | | | | | | | |
|---|---|--|---|--|---|--|--|--|--|--|--|--|
| dical Exan | that initiated events resulting in death) Last | that initiated events c | | | | | | | | | | |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | opic pregnancy er (specify) | | 23d. Date of delivery Month Day Year | | | | | | | |
| ed by P | Part II. Other significant conditions of | contributing to death but not resulting in the underly | ying cause given in Part I. | | o use contribute to the cause of death? 2 No 3 Probably 4 Unknown | | | | | | | |
| | | 24a. Was an autopsy performed? | prior to completion of cause of death? 1 □ Yes 2 □ No | | | | | | | | | |
| Be | 25. Was case referred to medical examiner? | Uppelteli | | th (Check only one) | | | | | | | | |
| မ | 1 ☐ Yes 2 📜 No | Hospital: 1 papatient 2 ER/Outpatient 3 | | ome 5 Residence | 6 ☐ Other (Specify) | | | | | | | |
| ation: | 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in | jury occurred | | | | | | | |
| Certific | 3 Suicide 6 Could not be determined | | actory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) | | | | | | | |
| Medical Certification: To | 29a, Certifier 1 | nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investi- and manner stated. | curred at the time, date and place gation, in my opinion, death occu | e, and due to the cause arred at the time, date a | e(s) and manner as stated. and place, and due to the cause(s) | | | | | | | |
| Σ | 29b. Signature and title of certifier | 7 40 0 | 29c. License number | I | Date signed (Month, Day, Year) | | | | | | | |
| | · Auna | Ostiolostia, MD | AT243894 x | 5-410 NO | wich 21,2009 | | | | | | | |
| | 30. Name and address of person who | completed cause of death (Item 23a) (Type, Print | 111.5. | 10 | ' H U A W. N | | | | | | | |
| | 31. Date filed (Month, Day, Year) | TROWSEN, M.V. | union 1 | Vemonsi | Jospital, MI | | | | | | | |
| te ar | MAR 2 4 20 | 32. registrar's Signature | Les established | | , | | | | | | | |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g889 3/24/09 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Elizabeth Anne Roth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
Feb. 3, HOSPITAL A6NES 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months 1 □ M 2 🔀 F 212-05-2997 1917 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examinar must be nytified at 1 ☐ Yes 2 X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 912 S. Rolling Road 21228 "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 TXNo If Yes, Give Year or Dates Specify: ò 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen O'Neill Mary Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 408 Bathurst Road; Catonsville, Maryland 21228 Patricia Litchfield Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) 3/20/2009 Loudon Park Baltimore, Maryland 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Sign ture of Funeral Se 23a. Part T. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oncestive **Physician** disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Pulmoraky OBSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physician and ned for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably Unknown Completed neec pothy Roiclis m 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe After this certificate 1 ☐ Yes 2 No 1 □Yes Division of Vital Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after Swithin 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and addre completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

State Registrar Saint Agnes Hospital Baltimore, MD

ARCURI

auiD

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Esther Roberts 5:51 AM 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1232 N. Potomac St. Baltimore n/a Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2√2 F 65 Director Mar.17,1944 212 46 3052 S.C Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at Director MD n/a Baltimore 1 XYes 2 ☐ No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? illed within 72 hours after death with 1232 N. Potomac St. 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) North Philadelphia 12 should be filed with and Mental Hygier 7 is marked other the 6 NTA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Louise ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other to once. Linda Roberts-Ollison (daughter) 3723 N. 16th St. Philadelphia, PA 19440 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery Mar. 24, 2009 Baltimore, Md. 4 ☐ Ponation 5 ☐ Other (Specify) 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home ture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Md 21213
Approximate Interval Between Onset and Death Immediate Cause (Final Physician Bleeding disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed buriai-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown 9 ☐ Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by End-stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☑ No 2 □No 1 ☐ Yes Attending Physician: After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Injury n 24 hours after death.

e Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ō Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064231 March 20, 2009 Witelle Estella MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1830 E. Monument St. Suite 416, Baltimore, MD 21205 Michelle Estrella 31. Date filed (Month, Day, Year) State MAR 24 Registrar

DHMH 17 Rev 1/2001

8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or CouMaryland 10d. Inside City Limits Yes 2 X No 10g. Citizen of What Country United States 14. Race - American Indian, Black, Specify: White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Forest Hill, Maryland Evans Funeral Chapel & Cremation Services-B 3 Newport Drive Forest Hill, Maryland 21050 Approximate Interva Between Onset and Death Division of Vital Records, P.O. Box 68760 Year Day 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of No Hospital or Attending Physician: Nursing Home 5 Residence 6 ✔ Other: Scene Certification n 24 hours after death. filled in by 28f. Location (Street and Number or Rural Route Number, City determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely g To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 21, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAR 2.4 2009

ORIGINAL

1635 hrs

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

| | | For State Registrar | State o | f Marylan | | artmer | | | nd Me | | iene | 009 | 092 | |
|--|----------------------------|---|--|--|-----------------------------|-----------------------------------|---------------------------|--|-------------------------|--|-------------------|-------------------------------|----------------------------------|-----------------------|
| Physicia /Medic | al | 1. Decedent's Name (First, Middle, I | C. | nher) | SWAN S | | Town or | Location of | | Date of Deat Month MARCH | Day 20 | Year 2009 ounty of Deat | 3. Time o | |
| Examine Funeral Director | er | 5. Social Security Number 6 220-07-8342 | Sex 1 M 2 M F | 7. Age (In yrs. 87 | last birthday) Yrs. | | LAW p | Hours | 3ww | Date of Birth (Month, Day, October | | BALTIN | nore | or Foreign Te, MD. |
| Maryland a-f ehow | tor | Usual Residence of Decedent 10a. State 10b. County Maryland Baltim | ore Coun | | y, Town or Lo altimo | | | | | | | | 10d. Inside C | |
| th with the 23a or 28i | Funeral Director | 10e. Street and Number 3833 East Joppa | Road | Apt.A1 | | 10f. Zij | Code 2 | 1236 | | 11 | - | ted St | , | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once. | <u>و</u> | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Fo | 2)(<u>1</u>) No | | Was Dece If Yes, spe 1 Yes | | spanic Orig n, Mexican, Specify: | in? (Speci Puerto Ri | ify Yes or No- can, etc.) | | Specify: W | | |
| within 72 ho ene. then "netur | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | | | ł. | kind of wo DO NOT L | ork done d se retired) | tion Juring most istan | | | | of Business ntist | | |
| uld be filed Aental Hygi rked other tic event, I | To Be C | 17. Father's Name (First, Middle, La Frederick Finke | st) | |) | | | | | First, Middle, M {lederl | | umame) | | |
| and 2 shoulealth and Norm 27 is main her trauma | | 19a. Informant's Name/Relationship Mr. Lee M. Quick | | <u> </u> | 3016 | Lyn | ndale | Road | | Route Number 7irgini | a Be | ach,VA | . 23452 | 2 |
| it. Pages 1 intment of H intant: If ite njury or ott | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie | cify) | | Place of Disponentery, cres | Rede | eemer | Cem. | Marc 20 | ch 24, | Balt | | Maryla | |
| permit. Pages Department of Important: If it any injury or once. | i (| 23a. Party Enter the disease, or coshody, ownearly failure. List or | · Min | h. | P Do not on | eace 2325 | York | Road | ative T | es Fune Lmonium | ral& , Ma | Cremat ryland | 2109 Cti | |
| w requires that the death certificate be executed a second a second and a should be detached for use as the burial-transit | lical Examiner | d | | | | | | | | | | | | |
| the death certifica the attending ph ched for use as th | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 1 ☐ Live I | tcome of pregna birth 2 Feta nant at time of d | I death 3 | ∃Ectopic p ∃ Other (s | | | | | 23 | 3d. Date of de Month | | Year |
| requires that the death een signed by the atter nould be detached for t | ed by Ph | Part II. Other significant condition | s contributing to d | eath but not res | ulting in the u | nderlying | cause give | on in Part I. | | 1 | oaccous es 2 🗆 | | o the cause of | |
| The la ete has page 2 | Complete | | | | | | | | | 24a. Was a autops perform | ned? | prior to death? | utopsy findings completion of | available cause of |
| Physician: this certific ral director, | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No | Hospital: | Inpatient 2 | ER/Outpatie | nt 3 D | OA Othe | | | Check only on e 5 ☐ Reside | | □Other (Spe | cify) | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funers! Director: After this certific completely filled in by the funeral director. | Certification: T | 27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no | tion | of Injury th, Day Year) | 28b. Time of Injury | f M | 28c. Injury Work | at | No 28 | d. Describe ho | ow injury | occurred | | |
| oital or Attending urs after death. ars! Director: Afte | | 4 Homicide determin | ed 286. Place build | e of Injury - At he ing, etc. (Specil | fy) | | | 4.4 | | Sf. Location (St City or Town | n, State) | | | nber, |
| n 24 ho n 24 ho he Fune pletely f | edicai | 29a. Certifier 1 Certifying (Check only 2 Medical Ex | Physician: To the transfer on the band man | e best of my kno basis of examina oner stated. | ation and/or in | n occurred ive stigatio | n, in my op | oinion, deat | th occurred | d at the time, d | ate and p | place, and due | s stated. e to the cause(| s) |
| To t To t | Σ | 29b. Signature and title of certifier | | _ | | 29 | c. License | | | 2 | 3 | signed (Mont | | |
| | | 30. Name and addr ss of & rson w | no completed cau | se of death (Iter | п 23a) (Туре, | Print) | | 0597 | | | | | 2009 | |
| Sta , Registr | | DEBURAH WATS 31. Date filed (Month, Day, Year) NAR 2 4 | 2009 A | Adgistrar's Signa | ature B. A | back | THWEST | 7 170 | SPOR | 54 | 01 0 | old co | URT RO. | 40 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2009 arc /Medical Facility Name (If not institution, give Examiner Gen Hosp ount HO war OW If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Sex 1 M 2 □ F Age (In yrs. last birthday) **Funeral** Months June 7,1928 Director 201-14-1969 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Woodbine Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 21797 USA items 23a 15606 Bushy Park Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any hijury or other traumatic event, the Medical Examiner must. I once. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Armed 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CEO Maryland Pools Pool Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ Charles Spero Esther Caplan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trojan Horse Drive Phoenix, Maryland 21131 Robert W. Spero / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State W☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/25/09 Garrison Forest Cem. Ownings Mill, Md. 21. Signature Fun Price Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson Md 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last (or as a consequence of): Division or Vital Records, P.O. Box 68760, use as the IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an was autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of ath fix Natural 2 Accident Date of Injury 28b. Time of 28d. Describe how injury occurred 28a. 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Howar

29d. Date signed (Month, Day, Year)

State Registrar Ross C. Donehower

Johns Hopkin

Registrar's Signature

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 19 4DOLPH :10 2009 SMALL WOOD 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GNIDE HOPKINS AT BAYVIEW MEDICAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth April 122, 1932 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Maryland 1 X M 2 □ F 76 213-28-7252 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Essex Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 800 Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married White 1 □Yes 2 No þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Bricklayer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Slaughter Adolph Louis Smallwood မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 800 Creek Road Baltimore, MD 21221 Barbara Smallwood/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, MD 03/25/09 22. Name and Address of Facility 300 Mace Connelly Funeral Home Ave. Bal of Essex MD 21221 Balto. 21. Signature of Funeral Service License 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acthyCardia **Physician** disease or condition resulting in death) minc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy 2 X No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this

Box 68760, P.O. of Vital Records,

Division

after death Director:

thin 24 hours a

within To the

Medical

State Registrar

completely filled in by the funeral director, Certification: To

1 ☐ Yes 2 📉 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

29a, Certifier

4 Thomicide

5 ☐ Pending investigation 6 ☐ Could not be determined

MD

1 Inpatient 28a. Date of Injury (Month, Day, Year)

2 ER/Outpatient 3 DOA 28b. Time of

1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 No

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number RES OOT

29d. Date signed (Month, Day, Year) なつ

21224

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

/prts

, HOPKINS AT BAYVIEW MEDICAL PATRICK SAFO 31. Date filed (Month, Day, Year)

4940 EASTERN AVENUE

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | 2 | 0 | 0 | 9 | 0 | 9 | 2 | - | |
|--|---|---|---|---|---|---|---|---|--|
|--|---|---|---|---|---|---|---|---|--|

| | | 1- For State Ce | rtificate o | f Death | | Re | g. No. | |
|---|--|--|----------------------|---|-----------------|--|---|--|
| Physicia Medical Exami | | 1. Decedent's Name (First, Middle,Last) | | | | Date of Death Month | Dav Year | 3. Time of Death 1316 hrs |
| Weulcai Exami | ilei | Robert G. Schroeder 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or I | Location of D | March 21, | 2009 4c. County of Death | | |
| | | Upper Chesapeake Medical Center | | Bel Air | | | Harford | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. 1 | last birthday) | If Under 1 Year Months Days s. | + | Min | (MM/DD/YYYY) 9. Bir Foreig 26 , 1954 Co | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City | , Town or Loca | tion | | | | 10d. Inside City Limits |
| * . | _ | MD Baltimore | Ī | Middle H | River | | | 1 Yes 2 X No |
| Maryland 28a-f show d at once. | ompleted by Funeral Director | 10e. Street and Number | | 10f. Zip Code | | 10 | g. Citizen of What Cou | ntry? |
| ith the Maryland 23a or 28a-f sho notified at once. | | 131 Riverthorn Road | | 212 | | | USA | |
| ter death w ", or items er must be | | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year | | as Decedent of Hisp Yes, specify Cuban, Yes 2X No | Mexican, Pu | (Specify Yes or No- lerto Rican, etc.) | 14. Race - Amer White, etc. | White |
| ours af atural camin | | 15. Decedent's Education (Specify only highest grade completed) | | nt's Usual Occupati | on (Give kind | | 16b. Kind of Business/ | |
| 21215-0036 uld be filed within 72 hours at Mental Hygiene. marked other than "natural c eveut, the Medical Examin | | Elementary/Secondary (0-12) College (1-4 or 5+) 2yrs | - | nost of working life. rts Mana | ager | | | Company |
| 15-C | ပ | 17. Father's Name (First, Middle, Last) Bobby Schroeder | | 1 | | ame (First, Middle, M arie Sah | · | |
| 2121; ould be fil Mental H marked c event, i | o Be | 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailir | ng Address (Street | | | Lender ber, City or Town, State | , Zip Code) |
| and 2 should be filealth and Mental ten 27 is marked traumatic event, | | Deborah Schroeder /wife | | | | | ltimore M | |
| of H | | | crematory or of | sition (Name of cent ther place) Cremato | | Date 03/26/09 | 20c. Location - City or Baltimor | |
| Baltimo permit. Pag Department Importanti injury or or | | 21. Shriptive of Tune at Shrvice Licensee | Co | | Funer | | | altimore MD 2122 |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line. | | | such as cardi | ac or respiratory arre | st, shock, or heart | Approximate Interval Between Onset and |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardio Due to (or as a consequence of Due t | | sease | | | | Death |
| , | edical Certification: To Be Completed by Physician/I | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | | | | | |
| W B is | | (Disease or injury that initiated events resulting in death) Last | of): | | | | | <u> </u> |
| executed an and al-transit | | dd | | | | | | <u> </u> |
| 760, icate be execut physician and the burial - tran | | IF FEMALE: 23c. If yes, outcome of preg | gnancy | | | | 23d. Date of deliver | <u> </u> y |
| x 68 h certifi tending use as t | | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown | leath | etal death 3 ther (Specify) | Ectopic pre | egnancy | Month | Day Year |
| that the deat ned by the att | | Part II. Other significant conditions contributing to death but not | resulting in the | underlying cause g | iven in Part I. | 23e. Did to | bacco use contribute to | the cause of death? |
| S, P.O. Lires that to a signed by d be detac | | | | | | | 2 No 3 Pro | |
| of Vital Records, ng Physician: The law require. Nfer this certificate has been simeral director, page 2 should t | | | - | | | 24a. Was a autop: perfor | sy prior to | utopsy findings available completion of cause of |
| tal Rec tian: The L certificate ! | | | | | | 1 Yes | No 1 Y | es 2 No |
| Vital I hysician: this certifi I director, | | 25. Was case referred to medical examiner? Wyse 2 No Hospital: 1 Inpatient 2 Hospital: 2 Hospital: 3 Inpatient 2 Hospital: 4 Inpatient 2 Hospital: 4 Inpatient 2 Hospital: 5 Inpatient 2 Hospital: 6 Inpatient 2 Hospital: 7 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 | ER/Outpatier | | Othor: | eck only one) ursing Home 5 | Residence 6 Othe | |
| n of Vital I ding Physician: After this certifi funeral director, | | 27. Manner of Death 28a. Date of Injury | 28b. Time of | | y at Work? | | ow injury occurred | |
| the eath | | 1 Natural 5 Pending 2 Accident Investigation | | 1 Y | es 2 No | | | _ |
| Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / | | 3 Suicide 6 Could not be determined (Specify) | nome, farm, stre | eet, factory, office b | uilding, etc. | 28f. Location (S or Town, S | | ural Route Number, City |
| To the Hos within 24 h completely | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | |
| | Σ | 29b. Signature and title of certifier | | 29c. License O.C.M | | | 29d. Date signed (Mo March 22, 2009 | nth, Day, Year) |
| | | 30. Name and address of person who completed cause of death (Iter | n 23a) | | | | | |
| | | Pamela E. Sputhall, MD Assistant Medical Exa | | 11 Penn Street | , Baltimor | e, MD 21201 | | |
| St Regis | tate trar | 31. Date filed (Month, Day, Year) 32. Registrar's Signal | La Sa | N. | | | | |
| DHMH 17 Rev 1/2 | 001 | 700100 70 | ORIGINA | | | 001 | | |

| 09-02216 | |
|-----------------|--|
| Sherry Shindell | |

| nerry Shindell | | State of Maryland / Department of Certificate of | | /lental Hy | _ | | 09 0921 | | | |
|---|------------------|---|--|------------------------------|--------------------------------|-------------------------------|--|--|--|--|
| Physicia | an/ | Registrar 1. Decedent's Name (First, Middle,Last) | | 1: | 2. Date of Deat | | 3. Time of Death | | | |
| edical Exami | | Sherry P. Schindell | | | Month March 18, | Day Year 2009 | 1957 hrs | | | |
| | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Loca | ation of Death | | 4c. County of De | | | | |
| | ш | 2917 Eastern Avenue | Essex | 511-de-0411- | To Date of Dist | Baltimore C | | | | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Months Days | f Under 24Hrs. Hours Min. | 1 | 5,1950 | Birthplace (State or Foreign Country) | | | |
| Director | | 212-60-3233 1 M 2XX 58 Yrs Usual Residence of Decedent | | | NOV. I | 5,1950 | MD | | | |
| any | | 10a. State 10b. County 10c. City, Town or Locati | ion | | | | 10d. Inside City Limits | | | |
| M. | ř | MD Baltimore Ess | sex | | | | 1 Yes 2 X No | | | |
| te Maryland or 28a-f show | Director | 10e. Street and Number | 10f. Zip Code | | 10 | 0g. Citizen of What C | Country? | | | |
| death with the Maryland or items 23a or 28a-f sho must be notified at once. | | 2917 Eastern Avenue | 21 | 221 | | USA | | | | |
| h with | Funeral | | s Decedent of Hispani es, specify Cuban, Me | | | - 14. Race - Ar White, etc | nerican Indian, Black, | | | |
| or deat | Fun | 1 Yes 2X No | | | , | | | | | |
| 1215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner. | by | or Dates: | Yes 2 X No sp | | ork done | Specify: 1 | White ss/Industry | | | |
| 2 hou | eted | Flomostory/Secondary/(0.12) College (1.4 or 5+) during m | ost of working life. DO | | | | oo maaaa y | | | |
| 21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical | Completed by | 12th Disak | orea | | | | | | | |
| 5-0 lled w Hygie I other | | 17. Father's Name (First, Middle, Last) | 18.M | Nother's Name (| First, Middle, N | Maiden Surname) | | | | |
| 121 d be fi ental arked | Be | Emmett Schindell | | | dys Ma | | | | | |
| s, MD 21215-0036 and 2 should be filed within 72 hours after tealth and Mental Hygiene. ten 27 is marked other than "natural", of traumatic event, the Medical Examiner. | 2 | | Address (Street and Judywoo | | | | | | | |
| and 2 fealth tem 2 traum | | _ | ition (Name of cemeter | | Date | 20c. Location - City | | | | |
| Baltimore, permit. Pages I an Department of Heal Important: If iten | | 1 Bural 2 X Cremation 3 Removal from State crematory or oth | herplace) v Cremato | ory 3/ | 23/09 | Baltin | more MD | | | |
| Itim ii. Pa artmer ortani | | 4 Donation 5 Other Specify | lame and Address of F | | | | | | | |
| Baltimore, MD 2: permit. Pages 1 and 2 should Department of Health and M Important: If item 27 is malniury or other traumatice | | Mary Valla | | 301 | | Ave.Bal | | | | |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. | ne mode of dying, such | h as cardiac or | respiratory arre | est, shock, or heart | Approximate Interval Between Onset and | | | |
| /Medical_ raminer | ì | Immediate Cause (Final disease a. Hypertensive atheros | clerotic o | cardiov | ascular | disease | Death | | | |
| ^ | | or condition resulting in death) Due to (or as a consequence of): complicated by cocaine use | | | | | | | | |
| | er | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | |
| 10 | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | | | | | | | | |
| cecuted 1 and - transit | Exa | events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 50, te be executed ysician and burial - trans | edical | \overline{X} UNPENDED \overline{X} AMENDED $\#1$ as noted, 2 | 3a, PII,27 | 7,perME | ,g890 4 | /10/09 TT | | | | |
| '60, ate be | | IF FEMALE: 23c. If yes, outcome of pregnancy | | | | 23d. Date of deli | very | | | |
| Box 68760, e death certificate but the attending physic ed for use as the but | Physician/N | past 12 months? | | Ectopic pregnar | су | Month | Day Year | | | |
| SOX leath c | /sic | 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Ott | her (Specify) | | | | | | | |
| D. Entry the arched | Completed by Phy | Part II. Other significant conditions contributing to death but not resulting in the u | ınderlying cause given | n in Part I. | 23e. Did to | bbacco use contribute | to the cause of death? | | | |
| , P.O, res that the signed by be detacl | | Obesity | | | 1 Yes | s 2 No 3 F | Probably 4 🗹 Unknown | | | |
| rds requi | lete | | | | 24a. Was autop | | autopsy findings available to completion of cause of | | | |
| eco he law te has | dmc | | | | | rmed? death | 1? | | | |
| nn: Ti | | 25. Was case referred to medical | 26.Place of D | Death (Check o | | 2 110 | 103 2 110 | | | |
| Vita nysicia this ce | To Be | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient | 3 DOA Othe | er ₄ Nursing | Home 5 | Residence 6 🗸 O | ther: Scene | | | |
| Division of Vital Records, P.O. Box 6876 Of the Hospital or Attending Physician: The law requires that the death certificat vitin 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending phonompletely filled in by the funeral director, page 2 should be detached for use as the | | 27. Manner of Death 1 X Natural 5 Deadles 28a. Date of Injury (Month, Day, Year) 28b. Time of In | | | 28d. Describe t | how injury occurred | | | | |
| | Certification: | 2 Accident Investigation | 1Yes | | - | = 187= | | | | |
| Division pital or Attent ours after death reral Director: | ijį | 3 Suicide 6 Could not be determined (Specify) | et, factory, office building | ing, etc. | 28f. Location (S or Town, S | | Rural Route Number, City | | | |
| file ou | | 4 Homicide | | | | | 71 | | | |
| To the Hos within 24 h | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | | |
| | Me | 29b. Signature and title of certifier | 29c. License nu | ımber | | 29d. Date signed (| Month, Day, Year) | | | |
| | | ('al Re HOODAIN | O.C.M.E | Ξ. | | March 20, 200 | 9 | | | |
| | ŀ | 30. Name and address of person who completed cause of death (Item 23a) | | | | 1 | | | | |
| | | | Street, Baltimore, | , MD 21201 | | | | | | |
| St | ate | 31. Date filed (Month, Day, Year) 32 Registrar's Signature | del | | | | | | | |

09-02136 Angel Shook Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ngei Snook | | State of Maryland / Departmen 1-For State Amend 10b per F.H.Ceff at | | , 0 | 200 | 9 0021 | |
|--|----------------|--|---|---|--|-------------------------------|--|
| Physicia | ın/ | Decedent's Name (First, Middle,Last) | | 2. Date of Death | | 3. Time of Death | |
| Medical Exami | ner | Angel Shook 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | Month March 16, 2 | 4c. County of Death | 0955 hrs | |
| | | Harbor Hospital Center | Baltimore | | N/A | | |
| Funeral | 1 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo | ay) If Under 1 Year If Under 24Hr. Months Days Hours Mir | _ | (MM/DD/YYYY) 9. Birth Foreign | | |
| Director | | 218-83-5668 1X M 2 F Usual Residence of Decedent | Yrs. 1 28 | Jan 1 | 18 2009 Maryland | | |
| any | | 10a. State 10b. County Balto. City 10c. City, Town or | Location | | | 10d. Inside City Limits | |
| Maryland 28a-f show 1 at once. | 亨 | Maryland An ne Arundel Brook | | | 2.55 32 147 5 | 1 Yes 2 X No | |
| ith the Maryland 23a or 28a-f sho notified at once. | Director | 10e. Street and Number 3571 Horton Ave | 10f. Zip Code | 10 | g. Citizen of What Count | ry? | |
| with the ms 23a | eral [| 11. Marital Status 12. Was Decedent Ever in U.S. 1 | 21225 3. Was Decedent of Hispanic Origin? (S | | USA 14. Race - Americ | an Indian, Black, | |
| r death or iter must | Fune | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No | If Yes, specify Cuban, Mexican, Puerto | Rican, etc.) | White, etc. | | |
| irs afte tural", miner | δ | Tor Dates: | 1 Yes 2 X No specify: | work done | Specify: Bla 16b. Kind of Business/In | | |
| 5 72 hou in "nat | ompleted | Elementary/Secondary (0-12) College (1-4 or 5+) | ring most of working life. DO NOT use ref | tired) | | | |
| 5-0036 led within 72 hours afte frygiene. other than "natural", the Medical Examiner | omp | 0 0 17. Father's Name (First, Middle, Last) | N/A | e (First, Middle, M | N/A | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | Be C | Joseph T.H. Shook | | | hardson | | |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other transmatic event, the Medical Examiner must be notified at once | ြ | Prince and the second s | Mailing Address (Street and Number or | | • | | |
| Baltimore, MD 2 permit, Pages and 2 shoul Department of Health and M Important: If item 27 is in july or other transmatic. | | 20a. Method of Disposition 20b. Place of Disposition | Disposition (Name of cemetery, | Brookly: Date | n , Md . 21 : 20c: Location - City or T | | |
| Baltimore, permit. Pages I an Department of Hea Important: If ite | | The bullar 2 X Cremation 3 Removal from State | or other place) Crematory 3-2 | 23-09 | Baltimore | 5 M A | |
| Salti ermit epartm mporta ijury o | | 21. Signature of Funeral Service Licensee | Will Reese & Son | ns Mort | uary, P.A | . Mu | |
| Physician | 1_0.6 | Zavry 1. Heen MO483 23a. Part Enter the disease, or complications that caused the death. Do not e | 821 West St. Ar | napoli | s. Md 21 | 4 0 1 Approximate Interval | |
| /Medical xaminer | 10 | failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexplaine) | | | | Between Onset and Death | |
| \allinei | | or condition resulting in death) Due to (or as a consequence of): | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | | | | |
| 112 - | Exami | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | |
| recuted and rans | | d. 23a.2/.28a- | f,perME, g891 5/14, | /09 TT | | | |
| iox 68760, eath certificate be executed e attending physician and for use as the burial - transi | Wedical | IF FEMALE: 23c. If yes, outcome of pregnancy | -,, 8-,,, | | 23d. Date of delivery | | |
| 687(certifica ding pl | sician/N | 23b. Was decedent pregnant in the past 12 months? | Fetal death 3 Ectopic pregn | ancy | Month Da | ay Year | |
| Box 687 e death certific the attending p ed for use as th | ysic | 1 Yes 2 No 9 Unknown 9 Unknown | Other (Specify) | | | | |
| ch the | by Phy | Part II. Other significant conditions contributing to death but not resulting in | n the underlying cause given in Part I. | | pacco use contribute to the | | |
| ords, P.C. w requires that us been signed I | | | | 1 24a. Was a | | opsy findings available | |
| e law re e has be | Completed | | | autops perforr | y prior to co ned? death? | empletion of cause of | |
| tal Rectian: The certificate ector, page | ادہ | 25. Was case referred to medical | 26.Place of Death (Check | 1 Yes 2 only one) | No 1 Yes | 2 No | |
| Division of Vital Records, tale or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be | To B | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outp | Toward Committee | | Residence 6 Other: | | |
| on of ading Pt. th. r: After te funeral | | 1 Natural 5 (Month, Day,Year) | ne of Injury 28c. Injury at Work? | unk | ow injury occurred | | |
| Visic or Atte fiter dea Directo in by th | Certification: | 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm | - | 28f. Location (Si | treet and Number or Runate) 35/1 Hort | al Route Number, City | |
| Di spital hours a neral I | Cert | 4 Homicide determined (Specify) Found at | | Brookly | n, MD | | |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: | edical | (Check only one) 2 Medical Examiner: On the basis of examination and/or inve | | | | | |
| To COM | Mec | and manner stated. 29b. Signature and title of certifier | 29c. License number | | 29d. Date signed (Mon | th, Day, Year) | |
| | | D_rOLIMO | O.C.M.E. | | March 17, 2009 | | |
| _ | | Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD | 111 Penn Street, Baltimore, N | ID 21201 | | | |
| | ate | 31 Date filed (Month, Day Year) 32 Registrar's Signature | | | | | |
| Regist | rar | MAR 2 4 2009 Denous B. A | and I | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year 12:57 PM 2000 DEOCA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** N/A niversite Mary Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (In vrs. last birthday) 9. Birthplace (State or Foreign 65. Age **Funeral** Months Days Hours Min May 13, 343 1**¥** M 2 □ F Mar 91 and Yrs. Director 215-42-1740 Usual Residence of Decedent 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2X No Glen Arm Maryland Baltimore 10e. Street and Number 10f. Zip Code . Citizen of What Country? 10g. Citi: or items 23a or 21057 5621 Bell Gwynn Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🕱 No þ Specify: Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Baltimore City Police Dept. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer and Mental Hygivis as marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jean Kolodziejski George Selby မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5621 Bell Gwynn Lane Glen Arm, Maryland 21057 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. Carol A. Selby/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/09 Towson Maryland Hilltop Service Corp. 21. Signature et Funeral Service Licenses Name and Address of Facility no Baltimore Maryland 5305 Harford Roád 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myeloccious disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to inmedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans olitis Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 🗆 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ⊟ Yes 2 🖬 1Ño 1 ☐ Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.
Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Medical 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)

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within 2 the

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32. Registra s Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rate

29c. License number

29d. Date signed (Month, Day, Year)

09-02182 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene William Lee Smith 09219 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3. Time of Death Month Day March 17, 2009 2355 hrs Medical Examiner William Lee Smith 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Bayview Medical Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 9-23-1984 MD 217-11-4202 1 X M 2 24 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 X Yes 2 No 28a-f show Dundalk MD Baltimore death with the Maryland Director 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country Apt. 1938 Oxley Road 21222 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14, Race - American Indian, Black, Funeral Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes Specify: White f Yes, Give Year Yes 2 X No specify: hours after Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) es 1 and 2 should be filed within 72 of Health and Mental Hygiene.
If item 27 is marked other than " Baltimore, MD 21215-0036 Carpet Installatidn 11 Carpet Installer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred J. Smith

19a. Informant's Name/Relationship (Type, Print) Virginia T.ee Cowen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 Tk MD 620 Four Georges <u>Virginia Randels</u> Mother Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State Department of Important: 1 Bayview Crematory 3-23-09 Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton Funeral Home pring Road, 21222 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Stab Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last rds, P.O. Box 68760, requires that the death certificate be executed Physician/Medical UNPENDED physician the burial -AMENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed' Yes 2 ✓ Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this ۵ 1 Yes 2 No 28a. Date of Injury (Month Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Certification: Subject stabbed Mar 17, 2009 UNKNOWN Natural 1 Yes 2 ✔ No Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 3101 Dundalk Avenue, Baltimore, MD (Specify) Unknown 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral

Registra

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State

Medical

(Check only

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month

and manner stated.

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 18, 2009

29d. Date signed (Month, Day, Year)

| | | | For State Registrar | State of Marylan | | epartment of F Certificate of | | Mental F | lygier Reg. 1 | 2000 | 09220 |
|--|--|----------------|--|---|-------------------|---|--|--------------------------------------|---------------------------|--|--|
| | Physicia /Medic | | Decedent's Name (First, Middle, La EVELYN | SIMON | <u></u> | | | 2. Date of Month | | Day th ZOO9 | 3. Time of Death 2:10 P M |
|) | Examin | | 4a. Facility Name (If not institution, gi | | PITA | _ | LSTOWN | | | 4c. County of Death BALTIMO | RE |
| | uneral irector | | | Sex 1 □ M 2 ▼ F 78 | | hday) If Under 1 Year Months Days | If Under 24 Hi Hours Min | | Birth Day, Yea 6, 1 | 9. Birthp Cour 930 MD | place (State or Foreign ntry) |
| yland | WOL | | 10a. State 10b. County | 10c. Cit | ty, Town | or Location | | | | 1 | 0d. Inside City Limits |
| e Mar | or 28a-f show | Director | MD BALTI | MORE | - | BALTIMORE | | | _ | | 1 ☐ Yes XX No |
| th with th | 23a or 2 | ral Dire | 10e. Street and Number 4723 BELLE FORT | E ROAD | | | 208 | | | Citizen of What Cour USA | itry? |
| U Z I Z I S-0050 filed within 72 hours after death with the Maryland Hydione | item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in U. Armed Forces? 1 □Yes 2▼ No If Yes, Give Year or Dates: | .S. | 13. Was Decedent of H If Yes, specify Cub | lispanic Origin? an, Mexican, Pue Specify: | (Specify Yes or erto Rican, etc.) | No- | 14. Race - Americ Black, White, Specify: W | |
| 72 hc | "natu | Completed | 15. Decedent's E (Specify only highest gi | ducation ade completed) | 16a. | Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | during most of w | orking | 16b. | . Kind of Business/Ind | dustry |
| withir | r than | dwo | Elementary/Secondary (0-12) | College (1-4or 5+) | | SALES PE | · | | HE | CHT COMPA | NY |
| oe filed | d other | BeC | 17. Father's Name (First, Middle, Las | | | | 18. Mother's Na | ame (First, Mid | | | |
| should be filed with | Is marked other aumatic event, | ဥ | HARRY SKLAF | | 105 | Mailing Address (Street | YETTA | | BASSU | | 0-4-) |
| T, Ma | 27 Is r r traur | 7 13 | 19a. Informant's Name/Relationship RUBIN SIMON / HUS | SBAND | | 723 BELLE F | | | | | Code) |
| Pages 1 a | Important: If item 27 Is any Injury or other tra | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | | Place of cemetery | Disposition (Name of y, crematory or other place | ce) | Date | 20c. | Location - City or To | wn, State |
| it. Pag | ntant: njury o | | 4 ☐ Donation 5 ☐ Other (Spec | ify) FOR | RBANI | 22. Name and Addre | d arm date | 2/2009 | | SEDALE, M | |
| permit. | any l | | 21. Signature of Funeral Service Lice | while | | 8900 REIST | SC | | | & BROS., | |
| | | 0 111 | 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only | nplications that caused the deat | h. Do n | | | | | , | Approximate Interval Between Onset and Death |
| | sician edical | | Immediate Cause (Final disease or condition resulting in death) | a Nonsmall | 0 | 1 Cancer | of the | Lung | | | Oliset and Death |
| | miner | | | Due to (or as a conseq | uence o | r): | | - | | | |
| pe | it. | iner | Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseq | uence o | (): | | | | | |
| , execut | sician and burial-transit | Examiner | that initiated events resulting in death) Last | c Due to (or as a conseq | uence o | f): | · | | | | |
| ate be | physicia the buri | edical | | d | | | | | | | |
| Sertifica | ding pl | | IF FEMALE: | 23c. If yes, outcome of pregna | anov | | | | | | |
| or Attending Physician: The law requires that the death certificate be executed after death. | ned by the attending detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 Live birth 2 Feta 4 Pregnant at time of 6 | al death | 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | ey . | | _ | 23d. Date of delive Month | ery Day Year |
| equires tha | been signed should be det | ğ | Part II. Other significant conditions | contributing to death but not res | ulting in | the underlying cause giv | en in Part I. | | | o use contribute to the | ne cause of death? |
| The law r | ate has page 2 | Completed | | | | | | | itopsy erformed | prior to condeath? | psy findings available mpletion of cause of |
| sician | this certificate al director, pag | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: | LED/O . | nationt 3 DOA Oth | OF: | eath (Check on | | - m. SEASE | MSHOSPICE |
| g Phy | After this funeral di | n: To | 27. Manner of Death | 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year) | 28b. T | patient 3 DOA | 4 LI Nursing | Home 5 ☐ R 28d. Descril | | 6 Dother Specifical formal for | n - 40 - Face |
| tendin leath. | tor: Af the fur | catio | 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not l | on and | | M 1 🗆 | Yes 2 □No | | | | |
| fal or At | al Directed in by | Certification: | 4 Homicide determined | | ome, far | m, street, factory, office | | | n (Street Town, St | and Number or Rura ate) | J Route Number, |
| To the Hospital | To the Funeral Director; A completely filled in by the fi | edical | | hysician: To the best of my knowing the common miner: On the basis of examinations and manner stated. | | | | | | | |
| To th | To th | Me | 29b. Signature and title of certifier | | | 29c. Licens | | | | Date signed (Month, | |
| | | | Melle 12 | ellen Bo | | HUS | 731 | | M | arch 20th | 1 2009 |
| | | | 30. Name and address of person who Debile But 31. Date filed (Month, Day, Year) | · · | 35 | Type, Print) Smith A | venue | sufe 2 | 203 | Bathmare | 4 2009 MD 21209 |
| | Sta Registr | | MAR 2 4 2009 | Access A. | | what | | | | | |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day Year BLANCHE SOSS 2102 AM /Medical March 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore bital Hos city If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Hours Min. 85 Director 180-16-8580 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at PHILADELPHIA Director 1 ☐ Yes 2 X No PHILADELPHIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 328 MERCY STREET 19148 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 21215-0036 1 □Yes 2**X**□No ģ Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnose. Elementary/Secondary (0-12) College (1-4or 5+) BELLVUE 8 CASHIER STRATFORD HOTEL Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HENRY SOSS YETTA JACOBS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3408 OLD FOREST RD; BALTIMORE, MD 21208 ALBERTA COOPERMAN / SISTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PHILADELPHIA, PA HAR NEBO CEMETERY MAR.22, 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Final) Mall le Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as 1c. nsequence of): disease or condition resulting in death) hours /Medical Examiner hours Sequentially list conditions Examiner Due to (or as a consequence of): if any, required to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.B.B.S March, 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGRAWBL KIREET 31. Date filed (Month, Day, Year) 32/Registrar's Signature State MAR 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registra 119222 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20^{ay} MARCH MIKHAIL SHUB 2009 10:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE CHERRYWOOD BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 04/10/1914 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex 1 M M 2 □ F **Funeral** Months Days Hours Min. BELARUS 212-19-0103 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Worldon Example in the could be conce. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE BALTIMORE Director 1 ☐ Yes 2 No 10f. Zin Code What Country? 106968anMARSUE DR. #1A 10g. Citizen of Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 2 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SALES WHOLESALE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ISRAEL SHUB SARA DURCHIN ၉ . Informant's Name/Relationship (Type. Print) ELIZABETH LIPSKY / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JESSIE CT., REISTERSTOWN, MD 21136 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date HAR SIŃAI 03/22/2009 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ster 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASCVD (Atherosderotic rardiovascular disease Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

29b. Signature and title of certified

31. Date filed (Mg

N.S. Rajapakse, MD

Day, Year)
2 4 2009

PalneMP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

25 Main St. , Suite 200, Reisterstown, MD. 21136

29d. Date signed (Month, Day, Year)

3/21/09

| | | | _ For | State of Marylar | nd / Depa | artment of H | lealth an | d Mental Hyg | iene | 00000 |
|----------------------------|--|------------------|---|---|------------------|--------------------------------------|------------------|---|-----------------------------------|--|
| | | • | State Registrar | | Cei | tificate of | Death | Re | 19. No. 11 U 9 | 09223 |
| | Dhysicis | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of Deat Month | h Day Year | 3. Time of Death |
| | Physicia /Medic | al - | Edward | Sacks | | | | MARCH | 20, 2009 | 1532 PM |
| | Examin | er | 4a. Facility Name (If not institution, giv | | | 4b. City, Town, o | | | 4c. County of Dea | |
| | | | 5. Social Security Number 6. S | ex 7. Age (In yrs. | last birthday) | If Under 1 Year | | Hrs 9 Date of Birth | 0.8 | rthplace (State or Foreign |
| 1 | Funeral Director | | | ©M 2□F 83 | Yrs. | Months Days | Hours A | Min. MAR.3, | 1926 | MD |
| | D . | | Usual Residence of Decedent | 100 6 | h. Town oal o | tion | | | | 10d. Inside City Limits |
| | ehow | _ | 10a. State 10b. County | | ty, Town or Lo | | | | | 1 ☐ Yes 2√ No |
| | the M | Director | MD BALTII 10e. Street and Number | MORE | BALTIM | 10f. Zip Code | - | 11 | ng. Citizen of What C | |
| | deeth with the Maryland | בַּ | 29 WARREN PARK I | ORIVE #A2 | | 21208 | 3 | | USA | ŕ |
| | me 23 | Jera | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | .S. 13. | Was Decedent of H | lispanic Origin | ? (Specify Yes or No- uerto Rican, etc.) | 14. Race - Am Black, Wh | |
| و | after or its | by Funeral | Never Married 2☐ Married | YOY GIVE | _ | 1 ☐ Yes 2 ☐ No | Specify: | 30110 1 110211, 010.7 | C!# | |
| 5-0036 | hours after turel', or ite | | 3 Widowed 4 Divorced | Year or Dates: WW I | 1 | dent's Usual Occup | ation | | 16b. Kind of Busines | ITE |
| 'n | within 72 lene. then "nat | Completed | 15. Decedent's E (Specify only highest gr | ade completed) | (Give | kind of work done DO NOT use retired | during most of | | TOD. KING OF BUSINESS | amoustry |
| 212 | y with | E O | Elementary/Secondary (0-12) | College (1-4or 5+) | T | ELLER | | | RACE TRACK | |
| 9 | be filed within 72 hours after dee ital Hygiene. Id other then "naturel", or iteme event, the Mc2lcal Examinar m | Be C | 17. Father's Name (First, Middle, Last |) | | | | Name (First, Middle, A | | |
| yla | | ٩ | | ACKS | | | | NNIE | FOX | 7-0-41 |
| Maryland 2121 | 12 sh h and 7 le m traum | | 19a. Informant's Name/Relationship | | | ESGARTH | | <i>r Rural R</i> oute <i>Number,</i> WINGS MILLS | | |
| | ges 1 end 2 should f of Heelth and Mer If item 27 ie marke or other traumatic | | STEVEN HINDS / 20a. Method of Disposition | FRIEND 20b. I | Place of Dispo | sition (Name of | | | 20c. Location - City o | |
| ē | 00 | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | Hemoval from State | | natory or other plac DROSH HAG | 1 | /23/2009 | ROSEDALE, | MD |
| Baltimore, | permit. Pag Department Important: f eny injury o | İ | 21. Signature of Funeral Service Lice | | | 2. Name and Addre | 4 - 100 | SOL LEVINS | • | |
| <u> </u> | 88 5 8 | | Routo | Jun > | 8 | 900 REIST | FRSTOW | N RD: BALT | IMORE, MD | 21208 |
| | | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only | plications that caused the dea one cause on each line. | th. Do not ent | er the mode of dyir | ng, such as car | diac or respiratory arre | est, | Approximate Interval Between Onset and Death |
| 4 | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. myocara | | marchin | | | | |
| | /Medical Examiner | | 1630((a)g iii dea(ii) | Due to (or as a consec | | 0. | | | | |
| | | e | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (units a nonsec | | rachelmorper | my | | | |
| | ate be executed sysicien and he burial-transit | Examiner | that initiated events | с. | | | | | | |
| Ó | te be executed ysicien and e burial-translt | | resulting in death) Last | Due to (or as a consec | quence of): | | | | | |
| 8760 | cate b | dicai | | d | | | | | | |
| × 68 | ding p | /Me | IF FEMALE: | 23c. If yes, outcome of pregn | ancv | | | | 23d. Date of de | alivery |
| Вох | The law requires thet the death certiticate size hes been signed by the attending phy page 2 should be deteched for use as the | by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | 1 Live birth 2 ☐ Feta 4 Pregnant at time of a | aldeath 3[| Ectopic pregnancy Other (specify) | ′ | | Month | Day Year |
| o. | thet fhe di ad by the deteched | hysi | 9 Unknown | 9□ Unknown | | | | | | |
| S, | igned be del | Бу Р | Part II. Other significant conditions | contributing to death but not re | sulting in the u | nderlying cause giv | ren in Part I. | | | to the cause of death? |
| ord | w require been si should I | ted | | | | | | 1 \ Y€ | s 2 No 3 F | Probably 4 2 Unknown |
| Ö | hes b | Completed | | | | | _ | 24a. Was a autops perforr | y prior to | tutopsy findings available completion of cause of |
| <u>=</u> | Physician: The la r this certificate hes ral director, page 2 | | | 1 | | | | 1 ☐ Yes 2 | 2 (X(No 1 □ Ye | |
| # | Physician: r this certifica ral director, I | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 ☑Inpatient 2 □ | ER/Outpatie | o# 3□ DO4 O# | 000 | Death Check only on | - | acity) |
| ō | Phy er this | H- | 27. Manner of Death | 28a. Date of Injury (Month, Day Year) | 28b. Time of | | ry at | - | w injury occurred | 00/19) |
| <u>o</u> | Attending is death. | atlo | 1 Natural 5 Pending 2 Accident Investigation | in | Injuty | | Yes 2 □ No | | | |
| Division of Vital Records, | or Atte | Certification: | 3 Suicide 6 Could not to determined | 28e. Place of Injury - At h building, etc. (Spec | nome, farm, st | reet, factory, office | | 28f. Location (St City or Town | reet and Number or F n, State) | Rural Route Number, |
| ۵ | ospitei o hours at unerei D ity filled ir | | | harining To the back of multi- | | | | lana and due to the e | | an etated |
| W | I 4 II G | Medical | 29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa | hysician: To the best of my kn miner: On the basis of examin and manner stated. | ation and/or in | vestigation, in my | ppinion, death o | occurred at the time, d | ate and place, and du | ie to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | | | 29c. Licens | se number | 2 | 9d. Date signed (Mor | nth, Day, Year) |
| | ,- > F 0 | | 001 | 4 in | | D | 00597 | 36 | march 20 | 2009 |
| | | | 30. Name and address of person who | | т 23а) (Туре, | | <u> </u> | | | · |
| | | | DESORAH WATSON | | hus. | MORTHW | est He | SPITAL | 5401 00 | COURT RAD |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | 200 | | | | |
| DH | MH 17 Rev 1/2 | - | THE WELL | 009 Duna | 13 17 | and . | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Date Month 3 **Physician** Zear Zear /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1106 Seneca Road Baltimore Co. Bowleys Quarters 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year f Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Yrs. Maryland 212-18-2168 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Enaminer must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Co. Bowleys Quarters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 1106 Seneca Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/AMachine Operator American Can Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felix Stachorowski Josephine Jarzynski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Ann V. Stachorowski 1106 Seneca Road Bowleys 21220 Quarters, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cem. 3-26-09 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Un9 10nths disease or condition resulting in death) /Medical Due to (or as management of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause of Clasease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si 7, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed certificate Yes 2 □ No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Lex1

Box 68760,

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

completely

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MO SMORE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3701

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

N. Charles Street Baltimore,

29d. Date signed (Month, Day, Year)

MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd 17 & 18 per FH G890 4/1/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23,200 9**Physician** Joseph Paul Scarfield 2:25a M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Stella Maris Hospice Baltimore Co. Timonium 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-19-1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 93 Director 218-07-5823 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examiner must be notified at 1XIYes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 O'Donnell Street 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 College (1-4or 5+) N/A Elementary/Secondary (0-12) Ship Builder/Stevedore Ship Construction 17. Father's Name (First, Middle, Last) Jim Sternative 18 Mother's Name (First, Middle, Maiden Surname)
Pasqalena Coppola
Unknown Be Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Four MIll Road Nottingham, MD 21236 <u> Joan Jaworski - Daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛭 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-27-09 St. Stanislaus Cem. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Pollet Vodac 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or nijury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□Yes 2**X**No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 1∐Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year. 29c. License number Dorother Maholland RSM CRNA R146961 +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOROTHEA MAHOLLAND, RSM CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 4 2009 Registrar

DHMH 17 Rev 1/2001

a.m.

Dennis Russell Sanders State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Russell 0200 hrs Dennis Sanders Medical Examiner Jr. March 18, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hvattsville 5604 Cypress Creek Drive #102 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year **Funeral** Country) Min 577-08-8982 Months Davs Hours Director 08-23-1982 Wash. 1X M 2 26 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No DC Washington 28a-f show Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3705 24th St. 20018 USA with the Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes $_{\text{Specify}}$ Black 9 Yes 2 X No specify: f Yes. Give Year hours after Divorced "natural" à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r injury or other traumatic event, the Medical E 21215-0036 Plumber Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dennis Russell Sanders Gail M. Wilson Be Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Baltimore, MD Dennis Sanders Sr./Father 3705 24th St. NE Wash. DC 20018 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Mt. Olivet Cem. 3-27-09 Wash. DC Donation 5 Other Specify: 22. Name and Address of Facility Ronald Taylor II FH 21. Signature of Funeral Service Licenses Tromo 10583 Middleport Ln. White Plains, MD Approximate Interval hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line M dical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical rending physician a use as the burial -AMENDED UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown а Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of death? performed' Yes 2 ✓ Yes No To the Hospiral or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Mar 18, 2009 Subject shot 0150 hrs 1 Natural Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 5604 Cypress Creek Road #104, Hyattsville, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. March 18, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Řussell Alexander MD. Assistant Medical Examiner 2. Registrar's Signature Day, Year State Registrar

DFIME 17 Rev 1/2001 **OCME 2006**

| | | | For | State of | Maryland | l / Depa | rtment of H | ealth an | d Mental H | lygiene | Э | |
|--|---|-------------------|---|---|---|-----------------|--|--------------------------------|---|-------------------------------|--------------------------|---|
| | | | State Registrar | | | Cer | tificate of L | Death | | Reg. No | 200 | 9 09227 |
| | Physicia | n . | 1. Decedent's Name (First, Middle, L | | | | | | 2. Date of Month | Da | | |
| | /Medic | al | Nathaniel A. | | | | | | Marc | | | |
| | Examin | er | 4a. Facility Name (If not institution, g | | | | 4b. City, Town, or | | eath | | . County of De | Arundel |
| , | Formula | | Anne Arunde1 5. Social Security Number 6. | | Age (In yrs. la | | Annap If Under 1 Year | If Under 24 | Hrs. 8. Date of | Birth | 9. 6 | Birthplace (State or Foreign |
| | Funeral Director | | 220-36-0010 | 1 ∑ M 2□ F | 6 | 8 Yrs. | Months Days | Hours N | Min. Aug_ | Bay, Year, 8 19 | 40 M | aryland |
| Pu | | | Usual Residence of Decedent 10a. State 10b. County | | 100 City | Town or Lo | cation | | | | | 10d, Inside City Limits |
| laryla | shov | ō | 10a. State 10b. County Maryland Anne | Arunde1 | | en Bu | | | | | | 1 ☐ Yes 2 🌠 No |
| the M | 28a-f | Directo | 10e, Street and Number | | | | 10f. Zip Code | - | | 10g. C | itizen of What | Country? |
| with | 3a or | | 7644 O'Daniel | Ct. | | | 2106 | 1 | | | USA | 4 |
| death | ems 2 | Funeral | 11. Marital Status | 12. Was Decede | | 13. | Was Decedent of Hi f Yes, specify Cuba | spanic Origin n, Mexican, P | ? (Specify Yes or uerto Rican, etc.) | No- | 14. Race - A Black, W | merican Indian, hite, etc. |
| d 21215-0036 fled within 72 hours after death with the Maryland | ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be morthed at | by Fu | 1 Never Married 2 Married | | ₹ ^{No} | | 1⊡Yes 2√∑No | Specify: | | | | Black |
| 5-0036 72 hours af | tural" | ed b | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's | | es: | 16a. Dece | dent's Usual Occupa | ation | | 16b. H | Kind of Busine | ss/Industry |
| 15 in 72 | n "na /edic | Completed | (Specify only highest s Elementary/Secondary (0-12) | grade completed) College (1-4 | (or 54) | (Give | kind of work done of DO NOT use retired | luring most of | working | Ĩ | | |
| 2121 9 ed within 7 | giene er tha | Com | 12th | 0 | .51 5+) | Ta | xi Comp | | | | | ployed |
| ng e | | Be (| 17. Father's Name (First, Middle, La | st) | | | | | Name (First, Mid | | n Surname) | |
| arylanoshould be 1 | nd Mental marked o imatic ev | 2 | Edward Thomas | (T. 51.1) | | 405 84-115 | ng Address (Street a | | ira Rig | | ar Taum Stat | ta. Zin Coda) |
| Mar d2sh | th and 7 is material | | 19a. Informant's Name/Relationship Darris Thomas | | r) | | | | | | | d. 21061 |
| 6 1 | if of Health and Men I if Item 27 is marke or other traumatic | 9 | 20a. Method of Disposition | - Daugiroc | | | Isition (Name of matory or other place | | Date | | | or Town, State |
| mo Pages | nent of ant: If Ite ury or o | | 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | | | 1 Garde | | -26-09 | An | napol: | is, Md. |
| Baltimore, Maryland permit. Pages 1 and 2 should be file | Department of Important: If any injury or once. | | 21. Signature of Funeral Service Lic | | | | Myame ReAddes | | | | | |
| m | B # E B | | | 2001483 | | | 21 West | | | | Md. 2 | |
| | | | 23a. Part 1. Enter the disease, or co shock, or heart failure. List or | mplications that cau ly one cause on eac | used the death ch line. | . Do not en | er the mode of dyin | g, such as ca | rdiac or respirato | ry arrest, | | Approximate Interval Between Onset and Death |
| | ysician | | Immediate Cause (Final disease or condition resulting in death) | a. Ano | Kic Er | cepa | lopety | | | | | 1 |
| | Medical kaminer | | resulting in death) | A - | r as a consequ | ence of): | - | | | | | |
| | | ē | Sequentially list conditions, | b. Due to (o | r de a corresiqu | enough. | 14 | | | | | 2 |
| cuted | ansit | Examiner | ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | e Hi | n per u | Cale | nice_ | | | | | |
| , 0 e exe | ohysician and the burial-transit | | resulting in death) Last | Due to (o | as a consequ | ence of): | 0 10 | | | | | |
| I Records, P.O. Box 68760, The law requires that the death certificate be executed | physic the bi | Physician/Medical | | d | 10 246 | - 16 | Lend D | sees | >- E | | | |
| x 6 certific | attending p for use as | /Me | IF FEMALE: | 23c. If yes, outco | ome of pregna | ncy | | | | | 23d. Date of | delivery |
| Box death cert | atten I for u | cian | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live bi 4 ☐ Pregna | rth 2 ☐ Fetal ant at time of de | death 3 | ☐ Ectopic pregnanc ☐ Other (specify) _ | y | | _ | Month | Day Year |
| P.O. | signed by the a be detached f | hysi | 9 Unknown | 9 ☐ Unkno | wn | | | | | | | |
| S, F | gned be det | by P | Part II. Other significant condition | s contributing to dea | ath but not resu | ilting in the u | nderlying cause giv | en in Part I. | | | | e to the cause of death? |
| ord | s been si | ted | | | | | | | _ | ☐ Yes | 2 No 3 | Probably 4 Unknown |
| e law r | hasbo le 2 sh | Completed | | | | | | | e | Vas an utopsy erformed? | 24b. Were prior deat | e autopsy findings available to completion of cause of h2 |
| a ∃ = H | certificate rector, pag | | | | | | | | 1 □ Y | es 2 🗷 | | Yes 2□No |
| Vit | certii | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | patient 2 | EB/Outpatia | nt 3 🗆 DOA Oth | or: | f Death <i>(Check o</i> i ing Home 5 ☐ I | | 6 □Other (| Spacify) |
| vision of Vita | h. After this certificate hi funeral director, page | n H | 27. Mannu Death | 28a. Date o | | 28b. Time o | | y at | | | ury occurred | эрсспу |
| ion | ath. rr: After ne funer | atio | 1 | tion | i, Day, Ieai) | mjury | | Yes 2 □ No | · | | | |
| Division of Vital Records, | ter de irecto n by th | Certification: To | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | 2d 2de. Place (| of Injury - At ho g, etc. <i>(Specif</i>) | me, farm, st | reet, factory, office | | 28f. Location City of | on (Street a r Town, Sta | and Number o. ite) | r Rural Route Number, |
| oital o | urs af eral D illed i | | 29a, Certifier 1 Certifying | Physician: To the I | hoot of my kno | wledge dea | th occurred at the ti | me date and | place and due to | the cause | (s) and manne | er as stated |
| The Hospital | within 24 hours after death To the Funeral Director: completely filled in by the | Medical | (Check only 2 Medical E | xaminer: On the ba | sis of examina | tion and/or in | nvestigation, in my | ppinion, death | occurred at the t | ime, date a | nd place, and | due to the cause(s) |
| 7 5 | vithin Fo the Sompl | Me | 29b. Signature and title of certifier | | | | 29c. Licens | | | 29d. E | ate signed (M | fonth, Day, Year) |
| | | | | | | | 1200 | ,0587 | 297 | 13/ | 19/00 | 7 |
| | | | 30. Name and address of person w | ho dompleted cause | of death (Item | 23a) (Type, | | 100 | Mode | 10 | Pr A | amples MV |
| | | | 31. Date filed (Month, Day, Year) | 4 OUN 327 | egistrar's Signa | tude / | THE AVE | 11114 | 1 1000 | Lety | 1 / 1 | 7 |
| | Sta Regist | | MAR 2 4 | 2009 Da | egistrar's Signa | 9. A | arks | | | | | |
| | | | | | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Month **Physician** 8:15 P. M March 21. Neofytos Theodore Tsangaris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 8814 Cold Spring Road Potomac If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Dec • 22 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Florida 1930 Dec. 78 Director 262-36-6186 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.
other than "natural" or items 23a or 28e-6 eb.com 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination in the rectified at 1 ∏Yes 2 ि No Director Potomac Maryland Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20854 8814 Cold Spring Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 XINo If Yes, Give Year or Dates: 1961–64 Specify. Specify: ⋧ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medicine Physician/Surgeon 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of þ Kalliope Gonatos Theodore Neofytos Tsangaris မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8814 Cold Spring Rd., Potomac, Maryland 20854 item 27 i Health Mary T. Tsangaris / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit, Pages Department of Important; If it any injury or o ŏ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March 27, 2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 21. Signature of Funeral S. vice Licensee Robert A. Pumphrey Funeral Home/Rockville 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart-failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical sequence (a) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial Box 68760 physiciar Physician/Medical the as attending l 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes by the a o 9 Unknown 9 Unknown <u>م</u> signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy page perform certificate 1 □Yes 2 HNO 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 - Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours at To the Funeral D the Hospital 29a. Certifier 1 🖳 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of ce and address of person who completed cause of death (Item 23a) (Type, Print) 30 Name 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

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| ら Division of Vital Records, P.O. Box 68760, | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Funeral Director: After this certificate has been signed by the attending physician and |

| | | State Registrar Decedent's Name (First, M | Middle. Last |) | | Ce | rtificate | OT DE | eath | | 2. Date of De | Reg. N | 10. 2 | 105 | 3. Time of Deat |
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| aminer | | a. Facility Name (If not insti | itution, give | street and numbe | r) | | 4b. City, T | own, or Lo | ocation o | f Death | | 4 | c. County | of Deatl | h |
| eral | 5 | 703 BENNING Social Security Number | | | ige (In yrs. I | last birthday, | If Under | 1 Year I | TIMORE ear If Under 24 Hrs. 8. Date of Bi | | | | N/1 | 9. Birtl | hplace (State or For |
| ctor | | 214-24-919 Jsual Residence of Deceder | 1 | x 7. A | 79 | Yrs. | Months | Days | Hours | Min. | 8. Date of Bi Month D 7-25- | MARYLAND | | | YĽÄND |
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| Director | | | N/A | | BA | ALTIMO | | | | | | 40 (| Citizen of | | txxYes 2□ |
| in in | | 0e. Street and Number 703 BENNIN | IGHAUS | RD. | | | 10f. Zip (| 1212 | | | | rog. c | USA | Wilat Co | unity: |
| irer must | 1 | 1. Marital Status | | 12. Was Deceden Armed Forces | t Ever in U.S | S. 13. | Was Decede | ent of Hisp | oanic Ori | gin? (Spe | ecify Yes or N Rican, etc.) | 0~ | | ce - Ame | rican Indian, |
| 2 | 2 | 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 【X Divo | | 1 Zes 2 If Yes, Give Year or Dates |] No | | 1 ☐ Yes 2 | | Specify: | , 1 40110 | , mount, otoly | | | y: BL | |
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| went, I | | 17. Father's Name (First, Mic | | | | | | | | r's Name | (First, Middle | e, Maide | | | |
| atic ev | | CHARLES TH | IOMPSO | N | | T:- | | | GEN | EVIE | EVE GOL | DSB | OROU | GH | |
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| any injury or other trai | 2 | DENISE FRA 20a. Method of Disposition | NKLIN | (DAUGHTE | | | 1 NORI osition (Name matory or other | | | | WHITEH Date | | | | ND 21161 Town, State |
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| e d | | farat | tu'(|) Stile | Bell- | _ 1 | 721-27 | 7 N. | MONE | OE S | T. BAL | TIM | ORE, | MARY | YLAND 212 |
| ian ical ner | | Immediate Cause (Final disease of condition resulting in death) | . List only of | na callea an aach | line | | | | | | or respiratory | | <i>د</i> ٠٠ | 2 | Approximate Interval Between Onset and Death |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b perFh 889 3/30/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 12:15P^M 22 2009 John R. Volpe March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5019 Baltimore National Pike **Baltimore** 8. Date of Birth (Month, Day, Year, June 24, 1 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours Months 1 ☑ M 2 ☐ F 80 1928 Pennsylvania 163-22-9425 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 ☐ No Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA 5019 Baltimore National Pike 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disability Examiner Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Volpe Barbara Laurita 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5019 Baltimore National Pike; Baltimore, MD 21229 Marian Volpe Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date /27/09 -27 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 LICH MO1537 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Emplysema 29 year Due to (or as a nsequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 4NO 1 ☐Yes 2 ♣No

Physician /Medical Examiner

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once.

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7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after or the Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or Ite

Baltimore, Maryland 21215-0036

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 25. Was case referred to medical examiner? 1 Yes 2√ No 27. Manner of Death 1 Watural 2 Accident 3 Suicide

4 Homicide

29a Certifier

State Registrar

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

BALIDNOTE

1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

D22114 DAMADON E, BARCKESS n

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

5 Pending investigation

6 ☐ Could not be

31. Date filed (Month, Day, Year)

NAR 2 4 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Physician 19 Victoria Josephine Witkowski 2009 2:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College Manor Lutherville Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 11, 1921 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 1 F Months Hours Min. 88 153-12-1016 Jersey City, N.J Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Modical Expedient must be notified at Director 1 ☐ Yes 2 No Lutherville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8408 Macauley Court 21093 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. other than Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked ott Be 27 is marked c traumatic ever Teofil Levandowski Anna Levandowski ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Peter Witkowski (Son) 8408 Macauley Court Lutherville, Maryland 21093 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 23, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Evans Funeral Chapel 4 □ Donation 万 □ Other (Specify) 2009 Forest Hill, Maryland 21. Signature of Funcial Service Licenses Name and Address of Facility tives Funeral & Cremation 2325 York Road Timonium, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mulvar 8 years disease or condition resulting in death) careinous / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician; The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 I Inknown 9 Unknown ģ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) Convaliscent 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident hours after deat uneral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, Citylor Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 24 and manner stated. one) within 2 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 28) (Type, Print) ROSENBERGO BRUCE 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. Certificate of Death 3. Time of Death dent's Name (First, Middle, Last Date of Death Year Month **Physician** a. M Williams larch 2009 /Medical give street and number) 4c. County of Death (If not institution. Town, of Location of Death **Examiner** timore 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 6 Sex **Funeral** Months Days Hours Min 1 M 2 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f show 1 Yes 2 No MDDirector alti More 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Nur 21229 IJSA Huenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 240 No 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2√1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. þ Blac 3 XWidowed 4 ☐ Divorced "natural" Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturenty Injury or other traumatic event, Its Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) altimore Elementary/Secondary (0-12) College (1-4or 5+) pervice Vorker 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surhame Be ဂ္ Mamie 19a, Informant's Name/Relationship (Type. Prin or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number Ballimore, 4006 21229 Kar ranston 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature if Funeral Service Licer Services Graciorene Fu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, any leading limited and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicisn: The law requires that the death certificate be executed burial-trar Division of Vital Records/ P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Tilnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □Yes 2 ☑No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ET/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗆 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the F and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ulus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L

State Registrar 31. Date filed (Month, Day,

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| 은 _ | 19a. Informant's Name/Relationship | | | 19b. Ma | iling Addres | s (Street a | | Rural Route Num | | | 'ip Code) |
| 1 | Karen D. Waesch | | | | - | | | ville, M | | | |
| 2 | 20a. Method of Disposition | • | | Place of Dis | position (Na | me of | 1 | Date | | ition - City or T | |
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| 1 | 21. Signature of Funeral Service Li | | Licit | | 22. Name a | ind Addres | s of Facility | Of Mary | | | |
| ă | Thomas Grego | | | | 299 Fr | reder | ick Road | d Baltim | ore. | Marylar | nd 21228 |
| Examiner | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b | r as a conseq | uence of): | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | rth 2☐ Feta int at time of d | al death | 3 ☐ Ectopic 5 ☐ Other (s | | у | 53 | | d. Date of del | Day Year |
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| n: T | 27. Manner of Death | 28a. Date of | Injury | 28b. Time Injur | e of | 28c. Injur Work | y_at | 28d. Describe | | | -/ |
| atio | 1 X Natural 5 ☐ Pending 2 ☐ Accident investiga | ition | , Day, Year) | Injur | M | | Yes 2 □ No | | | | |
| Certification: To | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | Zee. Place o | of Injury - At h g, etc. <i>(Speci</i> | ome, farm, | street, facto | ry, office | | | (Street and own, State) | Number or Ru | ural Route Number, |
| Medical C | 29a. Certifier 1☐ Certifying (Check only 2☐ Medical E | Physician: To the baxaminer: On the baxaminer | sis of examina | owledge, de ation and/o | r investigation | on, in my c | opinion, death o | ace, and due to the courred at the tim | e, date and p | olace, and due | to the cause(s) |
| Ž | 29b. Signature and title of certifier | | | | | 9c. Licens | _ | | | signed (Monta | |
| | Dorothesthe | holland, | esm o | CRNI | P | R14 | 16961 | <i>)</i> | 3~ | 23-0% | 7 |
| 5 [| 30. Name and address of person w DOROTHEA MAHOLL | no completed cause | of death (Ite | m 23a) (Typ | pe, Print) | | | | | D 2109 | |

MARCH 22, 2009 8:30 a.m. Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ج

DALE WAESCHE

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Jannie Williams 12 noon Mar 15, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore** 3804 Woodbine Avenue If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Director Feb 23, 1919 So. Carolina 578-26-1192 90 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shov must be notified at 28a-f shov 1X Yes 2 □ No Director Baltimore Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A 3804 Woodbine Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian "natural", or Items Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M once. Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma McCutheon Willie McCutheon ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3804 Woodbine Avenue Baltimore, Maryland 21207 Emma Bannerman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/21/09 Baltimore, Maryland 5 ☐ Other (Specify) Arbutus Memorial Park 21. Sign F neral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for □Yes 2□No 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2[No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို funeral 27. Manner of Death 1 D Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 | Yes 2 | No 2 Accident within 24 hours after death.

To the Funeral Director: , completely filled in by the f 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) BALT. ST. BALT, MD 09 30. Name and address of person w 1 (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar MAR 2 4 2009

| | | | For State Registrar | State of Ma | • | • | cate of L | | and ivid | - | giene Reg. No | 00 | 9 | nc | 235 |
|-------------|---|----------------|--|---|---------------------------------|--|-----------------------------------|--|-------------|---|------------------|------------|--------------------------------|--------------|-----------------------------|
| r | ji Di | Ģ. | Decedent's Name (First, Middle, Las | t) | | | | | | 2. Date of De | eath | | Year | 3. Time | of Death |
| | Physicia /Medic | | Nell Marie | Andre | wlevick | | | | | March | | 009 | | 4:3 | 38 A. ^M |
| | Examin | er | 4a. Facility Name (If not institution, give | · · | | 4b. | City, Town, or | Location on the control of the contr | | ci ek | 4c. | . County o | of Death alver | + | |
| - | <u> </u> | | Calvert Memorial 5. Social Security Number 6. Se | | (In yrs. last birthe | day) If U | Inder 1 Year | IICE F | | | rth | | | | te or Foreign |
| | Funeral Director | | | □M 2 X F | 79 Yr | Moi | nths Days | Hours | Min. | 8. Date of Bi (Month, Date 07 / 01 / | 1929 | | Count | ry) nesse | _ |
| | p | | Usual Residence of Decedent | | 40- O't- T- | | | | | | | | | | 05 11 11 |
| | arylar show | ٦ | 10a. State 10b. County MD Calver | | 10c. City, Town of | | ederic | l, | | | | | 10 | | City Limits |
| | the M | Director | MD Calver | L | LITH | | f. Zip Code | <u> </u> | | | 10a. Cit | izen of W | /hat Count | | - <u>71</u> |
| | aa or | | 182 Chesapeake | e Avenue | | | | 678 | | | . og. o | | J.S.A | - | |
| | death | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | Ever in U.S. | 13. Was [| Decedent of Hi , specify Cuba | ispanic Ori | gin? (Spec | cify Yes or No | p- | | - America | | |
| õ | or Ite | | 1 Never Married 2 Married | 1 GrYes 2 □ N If We s, Give | lo | | es 2 🗓 No | | ., | | | Specify: | 1. | ite | |
| 215-0036 | be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | ed by | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed | Year or Dates: | 1951-53 | ecedent's | Usual Occup | ation | | | 16h K | | siness/Ind | lustry | |
| <u>.</u> | in 72 n "na Medic | plet | (Specify only highest gra | de completed) College (1-4or 5- | () | Give kind of the side of the s | of work done of OT use retired | during mos | t of workin | ng | | | | ĺ | |
| 7 7 | d with giene er tha | Completed | Elementary/Secondary (0-12) | | -/ | | clerk | | | | U.S | · Pos | stal | Serv | ice |
| land | be file tal Hy d oth event | Be | 17. Father's Name (First, Middle, Last) | | | | | | | (First, Middle | e, Maiden | | | | |
| > | Men Men arke | P L | Douglas Guy 19a. Informant's Name/Relationship (7) | Lambert | | Acilina Ad | dress (Street a | | irgi | | City | Moor | | Co do) | |
| <u>a</u> | s 1 and 2 sho if Health and item 27 is ma other traums | | Leonard E. Andrew | | | - | | | | | | , | | , | 20678 |
| ē, | s 1 and f Health item 27 other ti | | 20a. Method of Disposition | | 20b. Place of D | | | | | ate | | | City or To | | |
| Ē | e = 5 | | 1 ☐ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | MD Vete | | | | 3/17, | /2009 | Che: | 1tenl | nam, | MD | |
| Baltimore, | permit. Pag Department Important: any injury once. | | 21. Signature of Funeral Service Licen | see | | | ne and Addres | | | | | | | | |
| П | 10 2 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 | | JADUE C | | | | Broom | | | | | Repu | ublic | | |
| | | | 23a. Part1. Enter the disease, or compands, or heart failure. List only Immediate Cause (Final | one cause on each lin | 1 1 | | | | | | | | | | nate Between nd Death |
| 7 | Physician /Medical | | disease or condition resulting in death) | a. Sever | consequence of | | memb | rano | PLS | (oli | ths. | | | Seu | enl |
| | Examiner | | | Due to (or as a | a consequence or, | | | | | | | | | N | eers |
| - 1 | B # | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a | a consequence of |): | | | | | - | | | | |
| | tificate be executed g phystcian and as the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | a consequence of | | | | | | | | | | |
| 68/60, | be ex clcian a | al E | | Due to (or as a | a consequence or, | | | | | | | | | | |
| 200 | tificate g phys as the | edical | | d | | | | | | | | | | | |
| X Q Q | | In/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | pf pregnancy 2 ☐ Fetal death | 3 □Ecto | pic pregnancy | , | | | | 23d. Date | e of delive | гу | |
| | The law requires that the death cel to has been signed by the attendir bage 2 should be detached for use | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregnant at | | | er (specify) | | | | | Mor | nth | Day | Year |
| л Э | hat the de d by the a letached | Phy | 9 ☐ Unknown Part II. Other significant conditions c | ontributing to death bu | ut not resulting in t | he underly | ring cause give | en in Part I | | 23e Did | tohaccou | use contr | ibute to th | e cause | of death? |
| ďŠ, | uires that signed k d be dett | d by | - Rtleg DVT | | it flot fooditing in a | no anaon, | mg dada gav | on mr are i. | | | | | 3 ☐ Prob | | Unknown |
| ecords, | w require been signature | Completed by | - Hopevtenin | re Canali | oversul |) cent | ding | ma | | 24a. Was | an | 24b. V | Vere autor | osv findir | gs available |
| Ď | The lar e has age 2 | duic | - 1) 0) - 1 - 130 | COMON! | o ver serve | av | 201346 | | | auto | | l p | rior to con l <u>ea</u> th? | npletion o | of cause of |
| VItal | | Be C | 25. Was case referred to medical | | | | | 26. Place | of Death | 1 Yes (Check only | -/- |) ! | ∐Yes | 2 No | |
| or < | Physical this ce | To E | examiner? 1 □ Yes 2√No | Hospital: 1 ☐ Inpatie | nt 2 ER/Outp | atient 3 | DOA Othe | er: 4□ Nu | rsing Hon | ne 5□Res | idence | 6 □Othe | er (Specify |) | |
| | Attending Physician: or death. ector: After this certific by the funeral director, | | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Injur (Month, Day | | ury | 28c. Injur Worl | K? | | 8d. Describe | how inju | ry occurre | ed | | |
| UIVISION | death ctor: / | icati | 2 Accident investigation 3 Suicide 6 Could not be | | ıry - At home, fam | N. street, fa | | Yes 2 | | 8f. Location | (Street ar | nd Numbe | er or Bura | I Boute A | lumber |
| 2 | i Pite | Certification: | 4 ☐ Homicide determined | building, etc | (Specify) | , | | | - | City or To | | | | | |
| | e Hospital 24 hours a e Funeral D letely filled i | | 29a. Certifier (Check only 2 Medical Exam | ysician: To the best on niner: On the basis of | of my knowledge, | death occ | urred at the tir | ne, date ar | nd place, a | and due to the | cause(s | and ma | nner as st | ated. | 20/e) |
| | the the | Medical | one) | and manner sta | ited. | OI HIVESTI | | | an occurre | ou at the thile | | | | | |
| | viti 70 | < | 29b. Signature and title of certifier | 10mans_ | 1110 | | 29c. License | 271 | 29 | | 29d. Da | | Month, I | 0 | 7 |
| , | \ | | 30. Name and address of person who | completed cause of de | ath (Item 22a) (To | vne Drint | | | <u> </u> | | J | 111 | 200 | 1 | |
| ev | DIALI | | | Completed cause of de | 11 (110111 230) (1) | 20 | BOX | 1239 | 9 | WAH | DOW | F | MO | 25 | HOU. |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

parker

32. Registrar's Signature

MAR -9 2009 ▶

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

lashington Street, Easton, MD 21601

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

d other than "natural", or iter event, the Medical Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

Completed

Be

completely filled in by the funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

| ical Examiner | Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L |
|-----------------|--|
| Physician/Medio | IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 □ 9 □ Unknown |
| completed by Ph | Part II. Other signif A Theros High I Hy se |

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Certification: To

Medical

State Registrar

25. Was c e referred to medical examiner?

2 No

29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

| the in I have | 700 Locust St., Cambridge, | MD 21613 | - •2• |
|--|--|--------------------------|--|
| 23a. Part1. Enter the disease, or c shock, or heart failure. List o | omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres | | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death) | a. Due to (or a, a consequence of): | |) days |
| Sequentially list conditions, | b. Due to (or as a consequence of): Due to (or as a consequence of): | zon | |
| if any, leading to Immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | c | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) | 23d. Date of de Month | elivery Day Year |
| Part II. Other significant condition AThero Scloro 17 | | . 1 | o the cause of death? |
| High Blood 1 | Hissure, Diasetes Mellitis Type Two, 24a. Was an autopsy mia, Chronic Renal Failure 10 Yes 2 | prior to | utopsy findings available completion of cause of |

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

DHMH 17 Rev 1/2001

within 24 hours after death To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Year **Physician** Idella M . Adams 52 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 ☐ M 2 🛣 F 92 Director 578-26-9834 11/2/1916 South Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c, City, Town or Location 10d. Inside City Limits ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exeminar must be nother Director 1X Yes 2 □ No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20003 1731 A Street, S.E. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Maryland 21215-0036 **Black** Completed by 1 □Yes 2K No Specify: Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Maid Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dobie Mack Arella Boyd ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Daniels - Daughter 251 Redtail Dr., Dover, DE 19904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cem. 3/11/2009 | Brentwood, Maryland 21. Signature of puneral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seps **Physician** 7 MAY /Medical Due to (or as a consequence of): Examiner wooles - AMSTERE Sequentially list conditions, Examiner Due to (or as é sonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burlal-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an nis certificate has director, page 2 s performed? Yes 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ♣ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signatur d title of certifier 29d. Date signed (Month, Day, Year) 226 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who cor ichon ~ 31 Date filed (Month, Day, 32 Registrar's Signatur State Registrar

ADAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 09238 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Virginia Adams March 15 2009 0630 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SunBridge Care Center Ceci1 E1kton Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🗓 F July 30, 1918 Maryland 213-30-8979 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 📉 No Maryland Ceci1 E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 224 Cherry Hill Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)

<u>Homemaker</u>

<u>In Her Own Home</u>

18. Mother's Name (First, Middle, Maiden Surname)

Mae Z. Brown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once. Baltimore, Maryland 21215-0036

1 - For State Registrar

10a State

11

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Edward T. Simmers

19a. Informant's Name/Relationship (Type. Print)

College (1-4or 5+)

Director

Funeral

ģ

Completed

Be

မ

Physician

Examiner

Funeral

Director

/Medical

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran s certificate has b irector, page 2 s within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

| | Elwood Adams/Son | | 347 9 | Stricke | rsville R | oad, Land | enberg. | PA 19350 | |
|------------------------|---|--|---|------------------------------------|---|---|---------------------|---|--|
| | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State | 20b. Place of Dispos cemetery, crem Brookview | ition (Name of atory or other p | 20c. Location - City or Town, State Rising Sun, MD | | | | |
| | 21. Signature of Funeral Service License | & Hich | 22. Hi | Name and Ad | dress of Facility | nerals, P treet, El | .A. | 21921 | |
| | 23a. Part 1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final | cations that caused the cause on each line | ne death. Do not ente | r the mode of o | | ac or respiratory arr | | Approximate Interval Between Onset and Death | |
| | disease or condition resulting in death) | Unknoon | | | | | | | |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| dicai Ex | resulting in death) Last | resulting in death) Last Due to (or as a consequence of): d. | | | | | | | |
| Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Month | | | | | | | | |
| 2 | Part II. Other significant conditions con | tributing to death but | not resulting in the un | derlying cause | given in Part I. | | | ute to the cause of death? | |
| Completed | | | | | | 24a. Was a autops perfor 1 □ Yes | sy prio | re autopsy findings available or to completion of cause of ath?]Yes 2 □No | |
| Be | 25. Was case referred to medical examiner? | | | | 26. Place of De | eath (Check only or | ne) | | |
| 0 | 1 Yes 2 No | | t 2 ER/Outpatient | 3 □ DOA (| Other: 4 Nursing | Home 5 ☐ Resid | ence 6 □Other | (Specify) | |
| ation: | 27. Manner of Death 1 | | | | 28d. Describe how injury occurred | | | | |
| Sertific | 3 ☐ Suicide 6 ☐ Could not be determined | | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Medical Certification: | ner as stated. d due to the cause(s) | | | | | | | | |
| Ž | 29b. Signature and title of certifier | 6 4 3 | | 29c. Lice | ense number | 2 | 29d. Date signed (i | | |
| | • Jackder | SMD | |) | 0023322 | 2. | 3.17. | 2009. | |
| | 30. Name and address of person who co | mpleted cause of dea | 4, F. Hig | 45+ | Elken | MD 219 | 21 | | |
| e r | 31. Date filed (Month, Day, Year) | 32. Registrar | 4 4 | ake | | | | | |
| | WHIT WILLIAM | | | | | | | | |

DHMH 17 Rev 1/2001

DX

State Registrar

| | | | For State | State of Maryla | | artment of F rtificate of I | | | 000 | 2 2 2 2 2 2 | |
|----------------------------|---|---------------------|--|---|---------------------------|---|--------------------------------------|--|--------------------------------------|---|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | Tincate of I | Dealii | 2. Date of Dea | Reg. No. 2 | 3. Time of Death | |
| | Physicia /Medic | | Lonnie E. Barnha | ırt | | | | Month March | 11, 2009 Year | 8:00 A ^M | |
| en. | Examin | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or | r Location of Death |) | 4c. County of Dea | | |
| , i | | | 11706 White Hall | Smiths | - | | Washingto | | | | |
| ı | Funeral Director | | 109-44-4410 | 7. Age (In yrs | s. last birthday) 5 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da June 22 | Year) 9. Bir G, 1953 Hag | thplace (State or Foreign ountry) erstown, MD | |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Lo | cation | | | | 10d. Inside City Limits | |
| | Mary a-f sh | tor | MD Washingt | on Sm | ithsbur | g | | | | 1 □Yes 2 No | |
| | or 28; | Dire | 10e. Street and Number | | | 10f. Zip Code | _ | | 10g. Citizen of What Co | ountry? | |
| | ath w | ral | 11706 White Hall | | 10 | 2178 | | | US | | |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Moder I Perio | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in the Armed Forces? 1 □ Yes 2 ¼ No If Yes, Give Year or Dates: | | Was Decedent of H f Yes, specify Cuba 1 □Yes 2 🏻 No | Ispanic Origin? (San, Mexican, Puert | pecity Yes or No- o Rican, etc.) | 14. Race - Am Black, Whit | | |
| 2-0 | 72 ho | eted | 15. Decedent's Edu (Specify only highest grade | cation e completed) | 16a. Deced | dent's Usual Occup | ation during most of wor | kina | 16b. Kind of Business | /Industry | |
| 121 | within iene. than " | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | owner | DO NOT use retired | 1) | | security c | ompany | |
| d 2 | e filed v al Hygie I other i vent, !!! | Be Co | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nan | | Maiden Surname) | J | |
| /lan | 2 should be and Mental is marked of aumatic eve | To B | Elwood R. Barnhar | ct | | | Thelma | L. Trum | power | | |
| lar) | 2 should n and Mer is marke raumatic | | 19a. Informant's Name/Relationship (Ty Kimberlee A. Barnl | | 1 | - | | | er, City or Town, State, | | |
| e, | 1 and 2 Health em 27 inther tra | ij | 20a. Method of Disposition | | | 06 White | | Date Smlt | hsburg, MD | | |
| nor | ages ent of nt: If it | | 1 ☑ Burial 2 ☐ Cremation 3 ☑ F 4 ☐ Donation 5 ☐ Other (Specify) | ternoval from State | | sition (Name of natory or other place Church C | | | 2009 Rouze | | |
| Baltimore, Maryland | permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other ance. | 1 | 21. Signature of Funeral Service License | | - W. | | | | | al Home, Inc. | |
| <u> </u> | B B E B | | James U. B | ochroy | | O S. Broa | | | | 68 | |
| | | | 23a. Part 1. Enter the disease, or complishock, or heart failure. List only or | cations that caused the dea ne cause on each line. | ath. Do not ent | | 100000 | | rest, | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Mete | stite | Colon | Cane | - | | 3 /2 4/1 | |
| 1 | Examiner | | Due to (or as a consequence of): | | | | | | | | |
| | D # | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underfain. Due to (or as a consequence of): | | | | | | | | |
| | ecute and -trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conse | guanaa afl: | | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | al E | | Due to (or as a conse | quence on. | | | | | | |
| | | ledical | | 1. | | | | | | | |
| Вох | tth cer tendir rr use | an/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet | | ☐ Ectopic pregnanc | v | | 23d. Date of de | elivery Day Year | |
| P.O. E | ires that the death certific signed by the attending p i be detached for use as | Physician/M | 1 Yes 2 No 9 Unknown | 4 ☐ Pregnant at time of 9 ☐ Unknown | death 5 | Other (specify) _ | | | World | Day Feat | |
| ν. σ. | s that ined by | by Ph | Part II. Other significant conditions cor | ntributing to death but not re | sulting in the ur | nderlying cause giv | en in Part I. | 23e. Did to | bacco use contribute t | o the cause of death? | |
| ords | w require been sig should b | ed b | | | | | | 1 🗆 Y | res 2 □ Mo 3 □ P | robably 4 Unknown | |
| ecc | e law r has be ie 2 shi | Completed | | | | | | 24a. Was autop | sy prior to | utopsy findings available completion of cause of | |
| alF | n: The ficate r, page | | | | | | | 1 □ Yes | | s 2 No | |
| Ξ | rsicial s certi lirecto | Be c | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | lospital: 1 ☐ Inpatient 2 ☐ | T EB/Outpatier | oth Oth | er: | / | ne) lence 6 □Other <i>(Spe</i> | aciful | |
| J Of | ig Phy ter this neral o | Ü | 27. Manner of Death | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | | <u> </u> | | ow injury occurred | ocity) | |
| Sion | tendir eath. or: Al | catic | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | | M 1 🗆 | Yes 2 □ No | - | | | |
| Division of Vital Records, | l or Att after d Direct in by | Certification: To | 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Spec | home, farm, stre cify) | eet, factory, office | | 28f. Location (S City or Tow | Street and Number or Fi m, State) | ural Route Number, | |
| _ | Hospita 4 hours Funeral tely filled | Medical Co | | sician: To the best of my kr ner: On the basis of examir | | | | | | | |
| | To the within 2 To the complet | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. Licens | e number | | 29d. Date signed (Mon | th, Day, Year) | |
| | ->-0 | | Michael 1. | Chulun | mo | 0 | 41667 | | 3.11.0 | 9 | |
| 21 | 1.12 | | 30. Name and address of person who co | | em 23a) (Type, | , | | | | on MO | |
| <i>9†</i> | 1-15 | | Michael M 31. Date filed (Month, Day, Year) | Cornect 32. Begistrar's Sign | 111/0 | Nedi | oral Ci | mus | log ens! | on MO | |
| | Sta Registr | _ | MAR 13 20 | 09 Acres | 1. 1 | and I | | | | | |

| | | | For State Registrar | State of I | Maryland | | artment of F ctificate of a | | and M | | giene Reg. No. 20 (| 9 09240 |
|-------------------|--|-------------------|---|--|--|------------------------|--|----------------------------------|--------------|---|---------------------------|--|
| | Physicia | | 1. Decedent's Name (First, Middle, La Laura Marie BINA | | | | | 2. Date of Dea Month March | Day Y | 3. Time of Death | | |
| - | /Medic Examin | | 4a. Facility Name (If not institution, giv | 4b. City, Town, o | r Location of | of Death | T WAT CI | 4c. County of | | | | |
| خ مجر بد | LAdimii | | Washington Count | y Hospita | 1 | | Hager | stown | 1 | | Washi | ngton |
| | Funeral Director | | 5. Social Security Number 6. S | | Age (In yrs. la | st birthday) Yrs. | If Under 1 Year Months Days | | | 8. Date of Birt (Month, Da Oct. 2 | h y, Year) | Birthplace (State or Foreign Country) Maryland |
| | pu , | | Usual Residence of Decedent | | I 100 City | Town or Lo | antion | | | | | 10d. Inside City Limits |
| | aryla shov | 'n | 10a. State 10b. County | | Too. City, | Town or Lo | | | | | | 1 □Yes 2X No |
| | the M | ect | Maryland Washi | ngton | | на | gerstown 10f. Zip Code | | | | 10g. Citizen of Wh | |
| | with with | Funeral Director | 13071 Little Hay | den Circl | e | | | 2174 | 12 | | USA | ŕ |
| | ms 2 | Jera | 11. Marital Status | 12, Was Decede | nt Ever in U.S | 13. | Nas Decedent of H f Yes, specify Cuba | | | ecify Yes or No | | - American Indian, |
| 21215-0036 | d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. 77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinator must be notified at | | 1 ☐ Never Married 2 ☐ Married 3 🖬 Widowed 4 ☐ Divorced | Armed Force 1 □Yes 2 If Yes, Give Year or Date | ™ No | | fYes, specify Cuba 1 □Yes 2⊠ No | an, Mexican Specify: | | Hican, etc.) | Black, Specify: | White, etc. white |
| 9-0 | 2 hot | Completed by | 15. Decedent's En (Specify only highest gra | ducation | | | dent's Usual Occup | | t of worki | na | 16b. Kind of Busi | ness/Industry |
| 21 | within 7 iene. • than "r | nple. | Elementary/Secondary (0-12) | College (1-4 | or 5+) | life. L | DO NOT use retired | d) | t or working | , ,g | | 1 |
| 12 | filed within Hygiene. other than " | | 12 | 0 | | se | cretary | 10 Matha | r'o Namo | /Eirot Middlo | nursin Maiden Surname) | g home |
| Maryland | ntal Hed otl | Be | 17. Father's Name (First, Middle, Last) John L. Jones |) | | | | | | | h Boyles | |
| Σ | 2 should be f and Mental Is marked oi aumatic eve | ပ္ | 19a. Informant's Name/Relationship | (Type Print) | | 19h Mailir | ng Address (Street | | | | er, City or Town, S | |
| ≅ | nd 2 s lith an 27 is r trau | | Douglas Jones - | ** | | | - | | | | | Maryland 21795 |
| ē, | s 1 and 2 of Health item 27 i | | 20a. Method of Disposition | | 20b. Pla | | sition (Name of natory or other place | | | ate | 20c. Location - C | |
| e e | Pages lent o nt: If i | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | | | | m Mem. P | | 3/12 | /09 | Hagersto | wn, Maryland |
| Baltimore, | permit. Pages 1 ar Department of Hea Important: If Item any Injury or othe once. | | 21. Signature of Funeral Service Lice | | ~ / | 7 22 | . Name and Addre | ss of Facilit | ty] | MINNICH | FUNERAL | HOME |
| B | Dep Imp | | COM! | Mun | nul | ~ 4 | 15 E. Wi | 1son | B1vd | ., Hage | rstown, 1 | Md. 21740 |
| | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only | | | . Do not ent | er the mode of dyir | ng, such as | cardiac o | or respiratory a | rrest, | Approximate Interval Between Onset and Death |
| - | Physician | | Immediate Cause (Final disease or condition | a. V- | en hi | cul | ur t | ach | ر درد | elibra | | Onset and Death |
| - Marie | /Medical Examiner | | resulting in death) | Due to (or | as a conseque | ence of): | | |) | | | |
| | | er | Sequentially list conditions, for any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | |
| | d d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | С. | | | | | | | | |
| oʻ | e exec an an rial-tr | | resulting in death) Last | | as a conseque | ence of): | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit | dical | | d | | | | | | | | |
| မ | ertifica ling pl e as t | Med | IF FEMALE: | | | | | | | | | |
| Вох | eath certific attending p for use as t | ian/ | 23b. Was decedent pregnant in the past 12 months? | | h 2 Fetal | death 3[| Ectopic pregnanc | у | | | 23d. Date Mont | |
| Ö | at the de by the a tached | Physician/Me | 1 □Yes 2 ⊡No 9 □ Unknown | 9 ☐ Unknow | nt at time of de | eath 5L | Other (specify) _ | | | | | |
| σ. | that 1 ned by detar | | Part II. Other significant conditions | contributing to deat | h but not resul | Iting in the u | nderlying cause giv | en in Part I | | 23e. Did t | obacco use contrib | oute to the cause of death? |
| of Vital Records, | quires in sign | d by | Brd-Stage Bers | e disos | se C | pron | nd pe | en A | Sea | ا□′ | res 2 1 No 3 | Probably 4 Unknown |
| S | sw require s been si should b | Completed | Diabeter me | Milho | 1 | | , | | | 24a. Was | | ere autopsy findings available |
| æ | : The law cate has I page 2 s | E | | | 1 | | | | | autor perfo 1 □Yes | rmed? _ de | or to completion of cause of ath? □Yes 2 □No |
| ita | sician: The certificate rector, pag | Be C | 25. Was case referred to medical examiner? | | | | | 26. Place | of Death | n (Check only o | | |
|) | Physic this ce al direc | | 1 Yes 2 THO | Hospital: 1 Inp | atient 2 🗆 E | ER/Outpatier | nt 3 □ DOA Oth | ner: 4□Nu | ursing Ho | me 5 Resid | dence 6 Other | (Specify) |
| 0 | Attending Physician: 9r death. ector: After this certifici | .:.o | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending | | Injury Day, Year) | 28b. Time of Injury | Wor | k? | | 28d. Describe | now injury occurred | 1 |
| sio | tendileath. | cati | 2 Accident investigatio | | 1-1 410- | | | Yes 2 🗆 | | 206 1 1 | 0 | B. J. B. A. March |
| Division | ء ڇَٰ ڇَٰ ڍ | Certification: To | 4 Homicide determined | Zoe. Flace of | njury - At nor , etc. <i>(Specify</i> | me, tarm, str | eet, factory, office | | | 28t. Location (3 City or Tox | | r or Rural Route Number, |
| | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | | | is of examinat | | | | | | | ner as stated. nd due to the cause(s) |
| | o the vithin o | Mec | 29b. Signature and title of certifier | and manner | StateU. | | 29c. Licens | se number | | | 29d. Date signed | (Month, Day, Year) |
| | ĕ ∓ ĕ ĕ | | June ~ | Deer | | | 400 | 6111 | 7 | | Nach | 10, 2009 |
| | | | 30. Name and address of person who | completed cause | of death_(Item | 23a) (Type, | | | | 111972 | ur Si | , , , |
| مح | 11-4 | | Francisco D | Donal | (Do | | H95 | 252 | | , MD | 2178 | < 2 |
| | Sta Registr | | 31. Date filed (Month, Pay, Year) MAR 10 2 | 009 32. Feg | istrar's Signat | ure. | arthol) | | | , | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 p Oneita Elmira Bramble 2009 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Mallard Bay Care Center Cambridge Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🔀 F 99 212-16-7987 Jan. 17, 1910 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a, State 10b. County show ns 23a or 28a-f show must be notified at 1 Yes 2 □ No Cambridge Dorchester MD Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 520 Glenburn Avenue 21613 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. r than "natural", or iten the Medical Examiner 1 ☐ Yes 2X No If Yes, Give Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ₩ Widowed 4 □ Divorced Year or Dates 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) food packing laborer 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Adams Clarence Dayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra 407 Glenburn Ave., Cambridge, MD 21613 Emerson T. Bramble son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/6/09 Cambridge, MD Dorchester Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infraoduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) ttending physician for us as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 🗌 Fetal death Month Day Year in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Tillnknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate has funeral director, page 2; 1□ Yes Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 DER/Outpatient 3□ DOA 1 🗌 Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending within 24 hours after death To the Funeral Director: filled in by completely

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

yen Street, Cambridge, MD-21613

State Registrar

2

| | | | For State Registrar | State of Maryla | • | tificate of L | | | eg. No. 200 | 9 09242 | | |
|------------------|---|----------------|--|---|-------------------------------|--|--|---|--|---|--|--|
| | Physicia | an | 1. Decedent's Name (First, Middle, Las | _ | | | Sr. | 2. Date of Deat Month | Day Yea | 3. Time of Death | | |
| | /Medic | al - | David 4a. Facility Name (If not institution, giv | Eugene | B: | rightful 4b. City, Town, or | | March 3 | 3, 2009 4c. County of De | 6:17 P ^M | | |
| | Examin | Ci | Kline Hospice Hou | | | Mt. Airy | | | Frederi | ck | | |
| U | Funeral Director | | 5. Social Security Number 6. S | ex 7. Age (In) XXM 2□ F 5 | yrs. last birthday) 7 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day) Jan, 5, | , Year) | Birthplace (State or Foreign Country) ryland | | |
| 70 | 2 3 | | Usual Residence of Decedent 10a. State 10b. County | 10c. | . City, Town or Lo | cation | | | | 10d. Inside City Limits | | |
| Monda | -f sho | tor | Maryland Frederic | k | Frederi | ck | | | | XXYes 2 □ No | | |
| 4 | 3a or 28a-f show | I Director | 10e. Street and Number 301 South Market | Street | | 10f. Zip Code 217 | 01 | 1 | 10g. Citizen of What USA | Country? | | |
| U Z I Z I J-0000 | s I am 2 should be lifed with the fours and locally with the way as if Health and Mental Hygiene. If Health and Mental Hygiene. other traumatic event, the Medical Eventre rount by malling and | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. Was Decedent Ever in Armed Forces? 1 | | Vas Decedent of Hi fYes, specify Cuba 1 □Yes 2 13 No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Al Black, Wi Specify: | merican Indian, hite, etc. Black | | |
| 0-0-1 | e. an "natur | Completed | 15. Decedent's E (Specify only highest gra- | ducation ade completed) College (1-4or 5+) | (Give | dent's Usual Occupa kind of work done o DO NOT use retired | luring most of work) | | 16b. Kind of Busines | | | |
| 7 | Hygien Her th | | 12 17. Father's Name (First, Middle, Last | 1 | T1 | ruck Driv | | e (First. Middle. | Short Hau1rst, Middle, Maiden Surname) | | | |
| ם ב | ental F ed of ced of | Be C | Herman | | ightful | | Edna | - (- / / | Jackson | | | |
| Ĕ | d z snould be med within the and Mental Hygiene. 77 is marked other than 'traumatic event, the Me | 2 | 19a. Informant's Name/Relationship Kevin Brightful/ | (Type. Print) | 19b. Mailir | ng Address (Street a | and Number or Ru al Street | ral Route Numbe | er, City or Town, State arket, MD | e, Zip Code) 21774 | | |
| ນ . ວ | permit. Fages I and a Department of Health Important: If item 27 i any Injury or other tra | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | J Removal from State | | sition (Name of matory or other plac n Mem. Ga | | Date 2009 | 20c. Location - City Frederick | | | |
| Dailillo | permit. P Departme Importan any Injur once. | | 21. Signature of Funeral Service Lice | - | 22 | 2. Name and Addres | s of Facility Sta | auffer F | uneralHome ederick,M | e, PA | | |
| | | | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final | one cause on each line. | death. Do not ent | ter the mode of dyin | g, such as cardiac | | | Approximate Interval Between On <u>set</u> and Death | | |
| | hysician /Medical Examiner | | disease or condition resulting in death) | a. Due to (or as a cor | | FNCER | | | | 58 MONTHS | | |
| | | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b Due to (or as a cor | consequence of): | | | | | | | |
| , o | incate be executed g physician and as the burial-transit | al Exar | that initiated events resulting in death) Last | C. Due to (or as a cor | nsequence of): | | | | | | | |
| 68760, | Tiricate ng phys as the | edical | | d | | | | | | | | |
| O. BOX | The law requires that the death certificate has been signed by the attending bage 2 should be detached for use a | hysician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death 3 | ☐ Ectopic pregnanc☐ Other (specify) _ | у | | 23d. Date of Month | delivery Day Year | | |
| ds, F. | ures that to signed by d be detac | by P | Part II. Other significant conditions | contributing to death but no | t resulting in the u | inderlying cause giv | en in Part I. | 23e. Did to | , | e to the cause of death?] Probably 4 ☐ Unknown | | |
| Hecords, | he la e has age 2 | Completed | | | | | | 24a. Was autop perfo 1 □ Yes | osy prior rmed? deat | e autopsy findings available to completion of cause of h? Yes 2 □ No | | |
| VITAI | cian: sertifica sctor, p | Be | 25. Was case referred to medical examiner? | Hospital: | | et 3 🗆 DOA Oth | 26. Place of Dea | | | Hospice | | |
| 10 U | iding Physician: th. After this certifica funeral director, p | on: To | 1 Yes 2 No 27. Manner of Death 16 Natural 5 Pending | 28a. Date of Injury (Month, Day, Yea | 2 ER/Outpatie | of 28c. Injur | ry at | | dence 6XXOther (s | Hospice Specify) House | | |
| DIVISION | deal deal ctor: y the | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | be 290 Place of Injury | At home, farm, st Specify) | | ies Z 🗆 ivo | 28f. Location (8 City or Tok | Street and Number o wn, State) | r Rural Route Number, | | |
| _ | To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the | Medical Ce | (Check only 2 Medical Exa | Physician: To the best of maminer: On the basis of examiner and manner stated. | amination and/or i | nvestigation, in my | opinion, death occu | urred at the time, | date and place, and | due to the cause(s) | | |
| | To the vithin To the comple | Mec | 30. Name and address of person when the state of the stat | 4 Elonos | MA | 29c. Licens | i 76/ | | 29d. Date signed (M | fonth, Day, Year) 6 2009 | | |
| | 4 | | 30. Name and address of person wh | completed cause of death | (Item 23a) (Type | , Print) SEVENTA | y St. | FRERE | MCK ML | 2701 | | |
| | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) | 2009 32. Registrar's | Signature . | bares | | | / | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 200 දී 07:00 Mary Genevieve Barnard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 911 Yardarm Lane Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth Month, Day, Year, 11/14/1921 9. Birthplace (State or Foreign 1 □ M 2 ⋤ F Months Days Hours Min. Washington, D.C. 87 579-18-2136 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 □Yes 2F No Anne Arundel Annapolis Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 United States 911 Yardarm Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madeline Donohue Milton Wheat Hubbard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Barnard/Husband Yardarm Lane, Annapolis, Maryland 21401 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) MD Veterans Cemetery 3-9-09 Crownsville, MD 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hsease-Severe Vascular erose Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform ver lension 2 [Z] No 1 ⊡Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the buria signed by the a

s certificate has be irector, page 2 sl after death Director: within 24 hours aft

To the Funeral Di

completely filled in

Physician

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the "Adical Examiner must be notified at

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the any once.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Certification: To

1 atural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Medical the

30. Name and address person who completed cause of death (Item 23a) (Type, Prin 31. Date filed (Manth, Day, State 092009 Registrar

29b. Signature and title of certifie

5 Pending investigation 1 ☐Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Month **Physician** March 3, 6:35 A M Beverly Russell Brown, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 2/27/1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1₽ M 2□ F Days Hours Washington, DC 82 577-30-3597 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Maryland Calvert Port Republic 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20676 USA 5010 Long Cove Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? M∑Yes ≥ □ No If Yes, Give Year or Dates: W.W. II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed and Mental Hygiene.
Is marked other than "natur-raumatic event, it a Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wonder Bread 12th Bread Man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Beverly Russell Brown Florence Avlene Gardner item 27 Is marke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Madeline M. Brown/ Wife 5010 Long Cove Ln., Port Republic, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 3/7/09 Kalas Crematory Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit. 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscierotic Cardio Vascular discose **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, the s been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Type one Diobetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? dibrillotio 24a. Was an autopsy performed Cordio Vasulai directe Hypertensive. 1 □Yes 2 ⊡No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 3-4.2009 Gyan C SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deale Churchton 31. Date filed (Month, Day, Year) State MAK U 9 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day} 2009 2:40 Charles Thomas Bowen, Jr. Αм March 7, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert 3607 28th Street Chesapeake Beach If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1⊠M 2□F Months 73 214-32-8190 1935 Washington, DC 28, Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Calvert Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20732 3607 28th Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married If Yes, Give Year or Dates: Korean 1 ☐Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Supervisor Industrial Construction 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles T. Bowen Elenore Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Bowen / Wife 3607 28th Street, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/2009 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DU ZC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a nonsequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 Ko 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

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The law requires that the death certificate be executed Physician: r this c or Attending hours after death To the Hospital within 24 hours a Medical completely

State Registrar 31. Date filed (Month, Day, Year,

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32. Registrar's Signature

and manner stated.

Type, Print)

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day PM Brinkman Morda Melvin Wesley 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Lions Center Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs. | Hours | Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Ye Nov 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours 234-42-9593 79 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 ☐ No 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? 21502 13311 Flower St-Potomac Park USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1948-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 1948-1950 Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Lance, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Wesley Irene Evans Brinkman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13311 Flower St Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Dixie Brinkman wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nethken Hill Cemetery 3/20/2009 Elk Garden WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Parkeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerotic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached to Completed by Be Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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r than "natural", or items 23a or 28a-f st the Medical Examiner must be notified

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Examiner

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Baltimore, Maryland 21215-0036

4 ☐ Homicide

6 ☐ Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Bishop Walshird, Cumberland, MD 21502 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

Medical

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09247 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary Bulkley Harvey Crosby 2009 March 8, 9:20 A. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Asbury-Solomons Health Care Center Calvert Solomons If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/11/1913 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 💢 F Michigan 217-42-0820 96 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 27 No MD Calvert Solomons 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20688 11740 Asbury Circle United States Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LeRoy Harris Harvey Mary Agnes Hatfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Thomas Harvey Crosby (Son) 46285 Cecil Rd., Lexington Park, Maryland 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/9/2009 | Alexandria, Virginia 21. Sign yur of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 Michae Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) W COMPLICATIONS CAR Due to (or as a consequence of): Sequentially list conditions, if any, leading to infill conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Durato (or as a consequence of) Due to (or as a consequence of):

Physician /Medical **Examiner**

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ral", or items 23a or 28a-f show Examiner must be notified at

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g physician and as the burial-transit attending physician for use as the buris signed by the a been si should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examine Completed by Physician/Medical Be Certification: To

Medical

John H. Weigel. MD

31. Date filed (Month, Day, Year)

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown | | Ectopic pregnancy Other (specify) | 23d. Date of delivery Month Day Year | | | |
|---|---|--|--|--|--|--|
| Part II. Other significant conditions co | ontributing to death but not resulting in the ur | nderlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? | | | |
| | | | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown | | | |
| | | | 24a. Was an autopsy performed? □ Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of deaths. | | | |
| 25. Was case referred to medical | | 26. Place of Deat | th Check onl one | | | |
| examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien | t 3 DOA Other: 4 Nursing Ho | ome 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred | | | |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injury · At home, farm, strobuilding, etc. (Specify) | eet, factory, office | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier 1 Lecrtifying Phyone) 2 Medical Exam | i ysician: To the best of my knowledge, death iner: On the basis of examination and/or in and manner stated. | n occurred at the time, date and place, vestigation, in my opinion, death occur | and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s) | | | |
| 29b. Signature and title of certifier | | 29c. License number | 29d. Date signed (Month, Day, Year) | | | |

126358

March 9, 2009

NEW 10

State

Registrar

110 Hospital Road, Suite 310, Prince Frederick, MD 20678

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200

| | | - | For State Registrar | State of Maryland | • | rtificate of I | | nomai riyg R | eg. No. 2 | 2009 | 09248 |
|----------------|--|----------------|--|---|---|--|---|--|--|----------------------------------|---|
| | Physicia | n | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat Month | Day | Year | 3. Time of Death |
| No. | /Medic | al . | Mary Alice | Location of Death | March | | 2009 unty of Death | 6:40 AM | | | |
| | Examin | er | 4a. Facility Name (<i>If not institution, giv</i> e s <i>t</i> 720 Irishtown Ro | | North | | Cecil | | | | |
| - 1 | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. la | ast birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, | Voar) | | lace (State or Foreign |
| | Director | | 217-26-3296 | M 2XXF 83 | Yrs. | Months Days | Hours Min. | Feb. 24 | | | |
| | and ow | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | - | 10 | Od. Inside City Limits |
| | Mary Ff sh | ţò | Maryland Cecil North East | | | | | | | | 1 □Yes 2/CXNo |
| | th the | Director | 10e. Street and Number | NO | Ten De | 10f. Zip Code | | 1 | 0g. Citizer | of What Coun | try? |
| | 23a | | 720 Irishtown Roa | đ | | 21901 | | | | ed Stat | |
| | er dez | Funeral | TT. Walta Status | 2. Was Decedent Ever in U.S Armed Forces? | 3. 13. \ | Was Decedent of H If Yes, specify Cuba | lispanic Origin? (Sp an, Mexican, Puerto | pecify Yes or No- Rican, etc.) | 14. | Race - Americ Black, White, e | |
| 36 | be filed within 72 hours after death with the Maryland at Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examit or must be rediffed at | by F | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ∐Yes 2 XNo If Yes, Give Year or Dates: | | 1⊡Yes 2∏XNo | Specify: | | Sp | ecify: Whi | te |
| 21215-0036 | 72 hou | Completed | 15. Decedent's Educa (Specify only highest grade | ation completed) | | dent's Usual Occup | ation during most of work | | 16b. Kind | of Business/Inc | lustry |
| 2 | filed within 72 Hygiene. other than "na ent, Ihe Modic | mple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. I. | DO NOT use retired | d) | 9 | | | |
| 22 | iled w Hygie ther ti | | 12 17. Father's Name (First, Middle, Last) | | Hon | nemaker | 18. Mother's Nam | ne (First, Middle, I | | | |
| Maryland | should be filed withir nd Mental Hygiene. marked other than matic event, Ibu M | To Be | David Mahoney | | | | | (Unknow | | | |
| ary | shoul ind M ind M i marl | ř | 19a. Informant's Name/Relationship (Typ | e. Print) | 19b. Mailir | ng Address (Street | and Number or Ru | | | own, State, Zip | Code) |
| | s 1 and 2 should if Health and Mer item 27 Is marke other traumatic | | John L. Cheadle / | - | L | | Road, No | | | - | 21901 |
| altimore, | Pages 1 al nent of Hea int: If item iry or othe | | 20a. Method of Disposition 1★Burial 2 ☐ Cremation 3 ☐ Re | emoval from State | ace of Dispo | sition (Name of matory or other place of Method ory | Marc | ch 12, | 20c. Locat | tion - City or To | wn, State |
| Ë | t. Pag rtmen rtant: rjury | | 4 ☐ Donation 5 ☐ Other (Specify) | | Cemete | ery | 200 | | | | Maryland |
| Bai | permit. Pages Department of Important: If it any injury or o once. | | 21. Signature of Euneral Service Censer | | 0.0 | | ss of Facility Cro | | | | y1and21901 |
| | | | 23a. Part 1. Enter the disease, or complice | ations that caused the death | | | | | | be, mar | Approximate Interval Between |
| 1 | Physician | | shock, or heart failure. List only one Immediate Cause (Final disease or condition | on each line. | 101 | Heart | failu | il | | | Onset and Death |
| | /Medical | | resulting in death) | / | Adam Decora Vicera | | | | | | |
| | Examiner | - | Sequentially list conditions, | Due o (or as a consequ | quence of: | | | | | SUR | YCCI " |
| | uted Insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | quence oi). | | | | | | | |
| oʻ. | exect an and rial-tra | Еха | resulting in death) Last | Due to (or as a consequ | quence of): | | | | | | |
| 68760, | tificate be executed g physician and as the burial-transit | ledical | d | | | | | | | | |
| | | | IF FEMALE: | Bc. If yes, outcome of pregna | nov | | | | | | |
| Вох | attending for use | cian, | in the past 12 months? | death 3 | ☐ Ectopic pregnand ☐ Other (specify) _ | 23d. Date of deli Month | | | Day Year | | |
| P.0. | at the de by the tached | Physician/N | 1 ☐ Yes 2 ☑No 9 ☐ Unknown | 4 ☐ Pregnant at time of d 9 ☐ Unknown | | _ otilot (opcony) _ | | | | | |
| S, | iw requires that s been signed t should be dett | oy P | Part Other significant conditions cont | tributing to death but not resu | ilting in the u | nderlying cause giv | en in Part I. | 23e. Did tobacco use contribute to the cause of death? | | | |
| Vital Records, | equire sen si ould b | Completed by | - Value ECS | 14/11/20 | 2000 | • | | 1 Yes 2 No 3 Probably 4 U | | | pably 4 ☐ Unknown |
| ěč | has be | nple | JOSTIC VUIL | Mar On | SECK | | | 24a. Was a autop: | sy | prior to co | psy findings available mpletion of cause of |
| <u>=</u> | yslcian: The law is certificate has t director, page 2 s | | /xyserten | 5/04 | | | | perfor 1 □ Yes | 2 🗆 No | death? 1 ☐ Yes | 2 🗆 No |
| Ĭ, | slciar certif | Be c | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | ospital: 1 ☐ Inpatient 2 ☐ | ED/Outpotion | ot all DOA Oth | or: | th (Check only or lome 5 X Resid | | Othor (Caral | |
| ō | y Physer this eral di | n: To | 27. Manner of Death | 28a. Date of Injury | 28b. Time o | f 28c. Inju | ry at | 28d. Describe h | | | <u>y) </u> |
| io | • Attending Physer death. rector: After this by the funeral di | atio | 1 Natural 5 Pending 2 Accident investigation | (Month, Day, Year) | Injury | M 1 | Yes 2□No | | | | |
| Division of | or Atte ter de irecto n by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At he building, etc. (Specification) | me, farm, str | reet, factory, office | | 28f. Location (S City or Tow | 8f. Location (Street and Number or Rural Route Number, City or Town, State) | | |
| Ω | To the Hospital or Attending Physician: The law requires that the death centuiting 24 hours after death. To the Funeral Directors After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use | | 29a. Certifier Certifying Phys | ician: To the best of my kno | wledge deat | th occurred at the t | ime date and place | and due to the | cause(s) ar | nd manner as s | stated |
| | e Hos 24 ho e Fun letely | Medical | (Check only 2 Medical Examin | er: On the basis of examina and manner stated. | tion and/or ir | vestigation, in my | opinion, death occu | irred at the time, o | date and pl | ace, and due to | the cause(s) |
| | To th within To th comp | Me | 29b. Signature and title of certifier | ' \ | | 29c. Licens | se number | - 1 | 29d. Date s | signed (Month, | Day, Year) |
| | | | 1/1/1/1/ | MAA | | I.D | 45155 | | 03/ | 11/20 | 009 |
| | 3 | | 30. Name and address of person who con | - / | 23a) (Type, | Print) | ms s | 1921 | - | | |
| | Sta | te. | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture | ne love | 1119 2 | - 6 - 1 | | | |
| | Pogietr | | | | Va. | 1 .1 | | | | | |

State of Maryland / Department of Health and Mental Hygiene 2 009 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:50 A M 2009 MARCH CHITTAMS FRANCIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CHERRY LANE NURSING CENTER LAUREL Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 15 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1₺ M 2□ F 81 MARYLAND 215-20-3108 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Extrairer must be rediffed at 1X Yes 2 No Director PRINCE GEORGE'S BELTSVILLE ME the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20707 USA ROAD 11409 EDMONDSTON Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Mayes 2 No Navy If Yes, Give Navy Year or Dates: BLACK 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Saltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT DEPT. OF ENERGY 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VIOLA THOMAS FRANCIS CHITTAMS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
134 FAYWOOD COURT # F GLEN BURNIE, MARYLAND 21060 19a. Informant's Name/Relationship (Type. Print) DENISE CHITTAMS/DAUGHTER item 27 i 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/12/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Juneral Service licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a I be detached for 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes X ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2\(\int\)No deain? 1 ☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARCH 10, 2009 3 D51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salazar MD 3621 LEGON ROAD ELLICOTT CITY, MARYLAND Andres 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01523 State of Maryland / Department of Health and Mental Hygiene Nelson Zelaya Claros Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day February 21, 2009 Physician/ 0338 hrs Zelaya Claros Nelson **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Hours Months Days Country Honduras None 04/15/1985 Director 23 1 X M 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Rockville Montgomery 28a-f show Md or items 23a or 28a-f sho must be notified at once. imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20853 Honduras 13102 Grenoble Rd. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Yes 1 Yes 2 No specify: Honduras Hispanic Specify: If Yes, Give Year Divorced "natural" 16b. Kind of Business/Industry ò 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) d other than ", Fast Food Cook tment of Health and Mental Hygiene.
rtant: If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marta Rutilia Claros Vasquez Jose Manuel Zelaya Quinteros 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13905 Broonall Ln, Silver Spring, Md. 20906 Baltimore, MD Jose Edgardo Amaya / Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition

1 A Burial 2 Cremation 3 Removal from State crematory or other place) 03/13/09 General Cemetery Other Specify: Donation 5 22. Name and Address of Facility John T. Rhines Funeral Home 3005 Sign rure of Funeral)S rice Licen 12th St. NE Wash. DC 20017 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death Mindical a. Head and Neck Injuries Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED UNPENDED physician the burial -Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year 3 ___Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth use as t past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions <u>Р</u> 1 Yes 2 V No 3 Probably 4 þ 24b. Were autopsy findings available Completed 24a. Was an Division of Vital Records, has been prior to completion of cause of autopsy performed' death? ✓ Yes No Yes 2 page certificate 26.Place of Death (Check only one) 25. Was case referred to medica Be Other examiner? Hospital: Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Passenger auto auto collision Certification: FOUND: Yes 2 V No 1 Natural 124 hours after death.

e Funeral Director: A etely filled in by the fu Pending Feb 21, 2009 0256 hrs 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) East Bound US Route 50, Cheverly, MD Could not be 3 Suicide determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the 1 one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 21, 2009 O.C.M.E 8

Registrar

OCME 2006

State

Ling Li, MD

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Marc 2009 Wa /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** washington Anne Medica len Burnie timore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Unde Birthplace (State or Foreign Country) **Funeral** 21228-4419 Months Days 1 □ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it o Medical Examinating matches nothing in 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 7720 GRACE AV 1.5.A. **Z** 1122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ 3 ₩idowed 4 Divorced Health and Mental Hygiene. em 27 is marked other than "natural", WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) BERTIE RUBY ERT SPENCER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau 77ZOGRACE ANE-PASADENA, MD. Z112Z) MARY LINDERBORN, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-18-09 HANDVER, MO. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Daugh ERTY FUNERAL HOME 2601 MOUNTAIN RD. PASADENA, MD.Z112Z or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each lin Approximate Interval Between Onset and Death Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final 2 years **Physician** Sex disease or condition resulting in death) uence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or e Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 No n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Jarch 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hwan ralm

DHMH 17 Rev 1/2001

DX

State Registrar Year)

31. Date filed (Month.

ORIGINAL

32. Registrar's Signature

| 09-02102 | | Please Type or Print in Black Inde | | | | ble. | | | | |
|---|----------------|---|--|--|---------------------------|--|--------------------------------|--|--|--|
| Brian Christophe | | | nent of Heal icate of Deat | | | 200 | 0 0005 | | | |
| | F | Registrar 1. Decedent's Name (First, Middle,Last) | cate of Death | | Reg. | No. | 3. Time of Death | | | |
| Physicia Medical Examir | | Brian Christopher Davis | | | Month E March 14, 2 | Day Year 009 | 2109 hrs | | | |
| MA | | 4a. Facility Name (if not institution, give street and number) | 4b. City, | Town, or Location of D | | 4c. County of Death | | | | |
| () | | Calvert Memorial Hospital | Princ | e Frederick | | Calvert | | | | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last to | | ler 1 Year If Under 2 | | (MM/DD/YYYY) 9. Birth Cou | nplace (State or Foreign ntry) | | | |
| Director | | 220-02-6387 1XM 2F 31 | Yrs. Month | hs Days Hours | Min. 03/03/1 | | Maryland | | | |
| | - | Usual Residence of Decedent | | | | | 10d. Inside City Limits | | | |
| w any | | | wn or Location | 1 D 1 | | | 1 X Yes 2 No | | | |
| yland -f sho | 힕 | MD Calvert 10e. Street and Number | Unesapea 10f. Zip | ake Beach | 100 | . Citizen of What Coun | | | | |
| e Mar or 283 | Director | 3606 27th Street | | 20732 | | U.S.A. | • | | | |
| death with the Maryland or items 23a or 28a-f show must be notified at once. | | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Was Decede | | ? (Specify Yes or No- | 14. Race - Americ | an Indian, Black, | | | |
| eath w | Funeral | 1 X Never Married 2 Married Armed Forces? | If Yes, speci | ify Cuban, Mexican, P | Puerto Rican, etc.) | White, etc. | | | | |
| ifter d | | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | 1 Yes 2 | 2 X No specify: | | Specify: W | nite | | | |
| ours a | d by | To: Bookson a Essential (aprent) they make a series of | | l Occupation (Give kir orking life, DO NOT us | | 16b. Kind of Business/Ir | ndustry | | | |
| 16 n 72 h ian "r | Set | Elementary/Secondary (0-12) College (1-4 or 5+) | | | | di sabla | | | | |
| 003 withi giene. | Completed | 17. Father's Name (First, Middle, Last) | nor | | Name (First, Middle, Ma | disable aiden Surname) | <u>a</u> | | | |
| 17215-0036 Id be filed within 72 hours after frelal Hygiene. narked other than "natural", event, the Medical Examiner. | BeC | Thomas Lee Davis | | | lia Fr <u>anc</u> | | | | | |
| | 10 E | | 19b. Mailing Address | | | er, City or Town, State, | | | | |
| 5 _ = 2 5 | | Thomas L. Davis, father | | | sapeake Bea | | 732 | | | |
| more, M Pages 1 and ent of Health: unt: If iten 2 | | | ce of Disposition (Na matory or other place | | Date | 20c. Location - City or | Town, State | | | |
| Pages nent of annt: I | | 4 Donation 5 Other Specify: | eterans C | | 03/24/2009 | Cheltenham | n, MD | | | |
| Baltimore, permit Pages I and Department of Heal Important: If item injury or other tra | _ | 21. Signature of Funeral Service Licensee | | d Address of Facility | | neral Home, | | | | |
| | 1 | 23a. Parri. Enter the disease, or complications that caused the death. Do | 8325 N | Mt. Harmon | y Lane, Owi | ings, MD 2 | 0736 Approximate Interval | | | |
| Physician /Medical | | failure. Ust only one cause on each line. | | o o, aying, odon do od. | and or respiratory arrow | -, | Between Onset and Death | | | |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Seizure disorder Due to (or as a consequence of): | | | | | | | | |
| | | Sequentially list conditions. | | | | | | | | |
| | iner | if any, leading to immediate Due to (or as a consequence of): | | | | | | | | |
| | Examine | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| tox 68760, eath certificate be executed attending physician and for use as the burial - transit | cal E) | d. | MT . 0.00 | 0. 2./21./00 | | | | | | |
| be exe | | XUNPENDED X AMENDED 23a,27,p | per me g8 | 90 ³ 4-20-09 |) vt | | | | | |
| 760 ficate ficate the by | sician/Med | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the | | | pregnancy | 23d. Date of delivery Month | y Day Year | | | |
| K 68 1 certi endin use as | iciar | past 12 months? 4 Pregnant at time of death | _ | | | | , | | | |
| Bo) e deatl the att | Phys | 1 Yes 2 No 9 Unknown 9 Unknown | | | i de più | | Maria de de esta O | | | |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit | | | ilting in the underlyin | ng cause given in Pari | , | 2 ✓ No 3 Prob | | | | |
| S, F uires m sign | Completed by | Hypertrophic Cardiomyopathy | | | 24a. Was a | | topsy findings available | | | |
| ord aw rec as bee | plet | | | | autops perfor | y prior to d | completion of cause of | | | |
| Rec The licate licate lipage | Som | | | | 1 ✔ Yes 2 | No 1 V Ye | es 2 No | | | |
| tal cian: certif | Be | 25. Was case referred to medical examiner? | R/Outpatient 3 | 26.Place of Death (C | | Residence 6 Other | | | | |
| fVi Physi er this | ဦ | 1 V Yes 2 No Impatent 2 V I | 8b. Time of Injury | 28c. Injury at Work? | | ow injury occurred | | | | |
| on on on on on on on on on on on on on o | ion | 27. Manner of Death 1 X Natural 5 Pending | | 1 Yes 2 | No | | | | | |
| iSiC r Atte er dea irecton | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom | e, farm, street, facto | ory, office building, etc | | | ral Route Number, City | | | |
| Divital or urs aftilled in | erti | Suicide 6 Could not be determined (Specify) | | | or Town, St | ate) | | | | |
| Hosp 24 ho Fune | | 29a, Certifying Physician: To the best of my knowledge | , death occurred at th | the time, date and place | ce, and due to the cause | e(s) and manner as stat | ed. | | | |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I | Medical | one) 2 Medical Examiner: On the basis of examination and and manner stated. | | | urred at the time, date a | | | | | |
| | Σ | 29b. Signature and title of certifier | 2 | O.C.M.E. | | 29d. Date signed (Mo March 15, 2009 | riur, Day, Fear) | | | |
| | | Will Company | | U.U.IVI.E. | | | | | | |
| | | 30. Name and address of person who completed cause of death (Item 2 Ana Rubio MD. Assistant Medical Examiner 1: | | , Baltimore, MD 2 | 21201 | | | | | |
| | tate | | | | | | | | | |
| Regis | | | W | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 060 2009 March Daniel Leo Donohue, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/10/1957 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Yrs. Director 216-52-9288 51 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or items 23a or 28a-f ehov the Madical Examiner must be notified at 1 ¥Yes 2 □ No Funeral Director Cambridge Maryland Dorchester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 Somerset Ave. 21613 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify: Specify: δ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Medical Publishing of Health and Mental Hygie If Item 27 Is marked other ir other traumatic event, ir permit. Pages 1 and 2 should be filet. Department of Health and Mental Hyror Important: if tem 27 ie merer eny injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Leo Donohue, Sr. Dorothy Ann Kable 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen C. Donohue / Wife 301 Somerset Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/7/2009 Mid Shore Cremation Center Cambridge, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alcoholi **Physician** /Medical travascular Cogalopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Examine this certificete has been signed by the ettending physicien and ral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Gastrointes Hal resulting in death) Last Due to (or as a consequence of): by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tailure 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed distuse CONVINION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2 No 2□ No 1 ☐ Yes 1 Yes ; After this certifical funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Da e of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending death. within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospitel Precritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the å 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000 618 22 30. Name and ddd ss of person who completed cause of death (Item 23a) (Type, Print) Cambridge, MD M.D. 321 Drahester Are. Widmile Brie J. 31. Date filed (Month, 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene State of Mental Hygiene ne , 2890,04/09/09dhb Reg. No.2 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year English ear 2 6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Tre de Calver H25, p.12 Memoria If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 578-01-4845 August 26, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Calvert Maryland Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14478 Solomons Island Road South 20688 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Proprietor Bed & Breakfast 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Joseph Gueo ပ္ Daisy M. Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Lee Siemon / Friend P.O. Box 233, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Washington National Cemetery 03/11/2009 Suitland, Maryland 21. Sign re of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. Trechael Kleren P.O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that be used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** congestive CENTRICATION APPROVED BY MESICAL EXAMINER /Medical Due to (as a consequence of): Examiner acure ren Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Hunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 **X** No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 X Yes 2XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA P this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MO D0061783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cleon 100 Hosp 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 12:01a. M FULLER Lorraine May March 7, 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) Days 1 □ M 2 🔀 F 220-40-0017 65 March 12,1943 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 8340 Neck Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married white 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 seamstress sewing manuf. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lloyd Hudson Eleanor Roadarme1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold R. Fuller - husband 8340 Neck Road, Williamsport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation March 10, Hagerstown Crematory Hagerstown, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 (1600 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Cardio disease or condition resulting in death) to (or as consequence of): reumm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last duran VO Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 \(\sqrt{\sqrt{U}}\) Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐Yes 2 No 26. Place of Death (Check only one)

28c. Injury at Work?

, Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Evar, and it is nottlied at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 2 may injury or other traumatic event, the Widcal Evan in 11 benonce.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

the Maryland

/Medical

10a. State

attending physician and for use as the burial-transi certificate has been signed by the rector, page 2 should be detached director. this funeral After t n 24 hours after death.

Ie Funeral Director: Aft
bletely filled in by the fun

Division of Vital Records, P.O. Box 68760.

Physician/Medical Be Completed by 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

Medical

4 Homicide

5 Pending investigation

6 ☐ Could not be

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

1500 Pennsylvania Avenue Hagerstown, MD 21742

State Registrar

Q5H-5

within 2.

31. Date filed (Month, Day, Year) MAR 10

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#1PERPHYS.PGC#3/9/09bi 1. Decedent's Name (First, 2. Date of Death 3. Time of Death Month Year · 2335M **Physician** 2 WILLIE THOMAS FOX JR. 2000 9 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimuse Hinore 5. Social Security Number Age (In yrs. last birthday)
65 Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 06/27/1943 9. Birthplace (State or Foreign Country) Wash., D.C. If Under **Funeral** Min. Days Months Hours 1 □XM 2 □ F 227-58-6793 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Md. Baltimore 1A Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 4601 Pallmall Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White etc. African-Armed Forces:

1 XYes 2 No
If Yes, Give 1964 Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1X Never Married 2 ☐ Married 1962-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: American þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Veteran Military 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Fox Fannie Green ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2344 Vermont Ave. # 101, Landover, Maryland 20785 Cynthia Fauntleroy/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any injury or ot
once. 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nat'l. Cem. 03/06/09 Triangle, Virginia 22. Name and Address of Facility ton & Sons Co., Inc. 4925 Burroughs Ave., N. E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee au 11261 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 80 Cal **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 🗌 Unknown s been si should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has e 2 s autopsy performed Yes 2 No certificate ha rector, page 2 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21400 1 Inpatient 2 PER/Outpatient 3 DOA After this of funeral direction Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 No investigation 2 Accident d in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number မှ 4+1 Name and address of person who completed cause of death (Item 23a) (Type, Print) I-ALL 101 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Ρ. Willie 2009 Forbes 27, 12:00 P February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 578-24-6399 Months Days Hours Min. 1 □ M 2 🛛 F 97 Director June 10. 1911 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examination is not be notified at once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** District of Columbia ty⊡Yes 2 □ No Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 825 Yuma Street, 20032 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: **Black** 3[™] Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Hotel Worker Private Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jim Bridgers ဂ Fannie Shackleford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Shackleford - Cousin 825 Yuma Street, SE Washington, DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State James Cemetery 4 ☐ Ponation 5 ☐ Other (Specify) Mar 10, 2009 Snow Hill, NC 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Lib 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each lyne. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (d Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to Examine Hospital or Attending Physician: The law requires that the death certificate be executed equence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pfonths? 1 ☐ Yes 2 X No Month Day Year 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Maprier of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ∠ □ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 29a, Certifier to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 29c. License number who completed cause of death (Item 23a) Type, Print) State

Registrar

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Rev. Thomas J. Fitzpatrick, O.S.F.S. March 16 2009 1414 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 Elkton Union Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Min. Months Days Hours 1 **X**) M 2 □ F JAN 23, 1932 Director 136-22-9171 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No Funeral Director Cecil Childs Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21916 United States 1120 Blue Ball Road Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Experiment once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: <u>م</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Priest Religious 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Fitzpatrick Clema Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oblates of St. Francis de Sales 2200 Kentmere Parkway, Wilmington, DE altimore, March 20, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oblate Cemetery Childs. MD 2009 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) archiethnia a **Physician** /Medical Due to (or as a consequence of): Cuknow Examiner SHALOD Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) nours after death.
neral Director: After this ce 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, been signed by the should be detached certificate has b To the Hospital or Attending Physician: uneral nours after death.

neral Director: Af
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| examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 105 DICE | | | | | | | | | | |
| 27. Manner of Death 1. Watural 5 ☐ Pending 2 ☐ Accident investigati | | | scribe how injury occurred | | | | | | | | |
| 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine | | | ation (Street and Number or Rural Route Number, y or Town, State) | | | | | | | | |
| | Physician: To the best of my knowledge, death occu aminer: On the basis of examination and/or investiga and manner stated. | | | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. License number | 29d. Date signed (Month, Day, Year) | | | | | | | | |

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State Registrar

Medical Certification: To Be

Familia Physicians 25 ADM 31. Date filed (Month, Day, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 68760. Records. of Vital Division

Baltimore, Maryland 21215-0036

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| | | | Decedent's Name (First, Middle, | Last) | 100/0 | 703 | | | 2. | Date of Dea | | Year | 3. Time of Death |
| | Physicia /Medic | | Mary L | ouise | | Gr | iffin | | | March | | 2009 | 7:58 P. M |
| | Examin | | 4a. Facility Name (If not institution, | - | | | | n, or Location of | f Death | | | County of Deat | _ |
| | | | 5615 Regency | | | - 4 b (-4b -4 - 3 | Sui | tland sar If Under 2 | A Hrs D | Date of Birth | | ince G | |
| | Funeral Director | | 219-32-5328 | | 75 | Yrs. | Months Da | | Min. 0 | Date of Birth (Month, Day 8/04/1 | 933 | Haro | thplace (State or Foreign buntry) Wood, Md. |
| | /land | ŀ | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | | 10d. Inside City Limits |
| | death with the Maryland rns 23a or 28a-f ehow r nout be notified at | 호 | Md. | P.G. | | Suitl | .and | | | | | | 1X Yes 2 □ No |
| | th the | Director | 10e. Street and Number | | | | 10f. Zip Cod | le | | 1 | 0g. Citiz | en of What Co | ountry? |
| | 23a | | 5615 Regency | Park Court | # 6 | | | 746 | | | | S.A. | |
| 1215-0036 | be filed within 72 hours after death with the Marylar tal Hygiene. d other than "naturel", or items 23a or 28a-1 ehow event, it a Medical Exagirar must be notified at | by Funeral | 11. Marital Status M Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent I Armed Forces? d 1 □ Yes 2 ☑ N If Yes, Give Year or Dates: | | l l | Was Decedent f Yes, specify (1 ☐ Yes 2 ☐ | of Hispanic Orig Cuban, Mexican, No <i>Specify:</i> | gin? (Specif , Puerto Ric | fy Yes or No- can, etc.) | | 4. Race - Ame Black, Whit Specify: 2 | |
| 7 | "natur | etec | 15. Decedent's (Specify only highest | Education grade completed) | | (Give | dent's Usual Oo kind of work do DO NOT use re | ne durina most | of working | | 16b. Kin | d of Business | Andustry |
| _ | within 72 ene. than "na! re Medic | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | | omesti | • | | | Pri | ivate I | industry |
| Maryland 2 | filed w Hygier other th | BeC | 17. Father's Name (First, Middle, La | est) | | | | 18. Mother | r's Name (F | First, Middle, | | | |
| <u>a</u> | | To B | Joseph Gri | ffin | | | | Id | da Pov | vell | | | |
| a | d 2 should I th and Meni 7 Is marka traumatic | | 19a. Informant's Name/Relationshi | | | | • | eet and Numbe | | | | | |
| | feaith m 27 in 27 | | James E. Young/S | 50n | Tani mi | 1921 | Village | Green | | | | | nd 20785 |
| Baltimore, | Pages inent of hand of hand of hand of hand of hand or ot | | 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe | ecify) | | rmony | sition (Name of natory or other Mem. Pa | ark 8 | /9/09")3/06/ | /09 | Land | | aryland |
| Bai | permit. Pag Department Important: any injury o | | 21. Signature of Funeral Service Li | N. GIATT | - | 4 | H.S.V 925 Bu | Vashingt roughs | on & Ave., | Sons C | o.,I ashi | inc. Ington, | D.C. 20019 |
| П | | | 23a. Part1. Enter the disease, or c shock, or heart failure. List or | omplications that caused nly one cause on each li | I the death ne. | . Do not ent | er the mode of | dying, such as | cardiac or r | espiratory arr | est, | | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition | a_ Lung (| Cance | r | | | | | | | 1 year |
| , | /Medical Examiner | | resulting in death) | Due to (or as | a consequ | ence of): | | | | | | | - |
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| o Î | exection and and rial-tra | Exa | resulting in death) Last | Due to (or as | a consequ | ience of): | | | | | | | |
| 98760 | ificate be executed g physician and as the burial-transit | edicai | | d | | | | | | | | | |
| _ | .≔ Oπ α d | /Med | IF FEMALE: | 23c. If yes, outcome | of prognar | 201 | | - | | | | | |
| P.O. Box | The law requires that the death certiff the has been signed by the attending tage 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal | death 3 | Ectopic pregn Other (specif | | | -15-25-5 | 2 | 3d. Date of de Month | livery Day Year |
| | res that signed b be deta | þ | Part II. Other significant condition | s contributing to death b | ut not resu | Iting in the u | nderlying caus | given in Part I. | | 23e. Did to | | | o the cause of death? |
| 9 | w requir been si should l | eted | | | | | | | | | | | |
| Division of Vital Records, | | Completed | | | | | | | | 24a. Was a autops perfor | sy | death? | utopsy findings available completion of cause of |
| Ĭ | ician certifi rector | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Other | | Check only or | | | |
| ö | Attending Physician: r death. sctor: After this certific by the funeral director. | To | 1 Yes 2 No 27. Manner of Death | 28a. Date of Inju | ry | ER/Outpatier 28b. Time of | nt 3□ DOA 28c. | 4 □ Nui Injury at Work? | | d. Describe h | | Other (Spe | ocify) |
| on | nding Phy ith. : After thi e funeral | ation | 1 Natural 5 ☐ Pending 2 ☐ Accident investiga | | y Year) | Injury | м | Work? 1 ∐ Yes 2 ∐ h | No | | | | |
| Divis | al or Attendate after death | Certification: | 3 Suicide 6 Could no 4 Homicide determin | | ury - At ho c. (Specify | me, farm, str | eet, factory, of | ice | 28 | f. Location (S City or Tow | | Number or R | ural Route Number, |
| | To the Hospital or At within 24 hours after of To the Funstal Dirac completely filled in by | edicai C | | Physician: To the best xaminer: On the basis o and manner st | f examinat | | | | | | | | |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | | | | | cense number | | | | signed (Moni | th, Day, Year) |
| 1 | 531 | | 30. Name and address of person w | the completed cause of c | leath (Item | 23a) (Tvna | | | | | 55,0 | 1100 | |
| | - 1-7) | | Nicholas DeMona | aco, M.D. 892 | 26 Woo | odyard | | 101,Cl | inton | ,Maryl | and | 20735 | |
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| | | - | Registrar 1. Decedent's Name (First, Middle | e, Last) | | Cei | rtificate of | Death | 2. Date of D | | 009 | 3. Time of Death |
| | Physicia /Medic | | EMELINE | | | ENWOOD | T | | MARCH | | | 4:15 A M |
| | Examin | er | 4a. Facility Name (If not institutio 14711 MT • CA | - | er) | | | r Location of Death R MARLBOR | | PRINCE GEORGE'S | | |
| | Funeral Director | | 5. Social Security Number 089-54-4087 | 6. Sex 7 1 ☐ M 2 ₹ F | Age (In yrs. I | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of B (Month, <u>D</u> AUG 7 | irth (ay, Yea <i>r</i>) 1917 | ace (State or Foreign ry) .CA | |
| | should be filed within 72 hours after death with the Maryland nd Mental Hygiene. The Hygiene is naturall, or items 23a or 28a-f show maric event, the Maryland Exeminant for rediffed at matic event, the Maryland Exeminant | Funeral Director | Usual Residence of Decedent | E GEORGE S PARKWAY # 12. Was Deceder Armed Force | GI 101 nt Ever in U.: | y, Town or Lo | 10f. Zip Code 20770 | dispanic Origin? (Sj an, Mexican, Puertc | pecify Yes or N | 10g. Citizen o USA | of What Count | an Indian, |
| 213-0030 | 72 hours after natural", or it licel Exemin | b S | 1 Never Married 2 Mar 3 Widowed 4 Divorced | ried 1 ☐ Yes 2 [| ∭No | 16a. Dece | 1 ☐ Yes 2 🛣 No | Specify: | | Spec | | BLACK |
| 0 Z 1 Z 1 | filed within 7 Hygiene. other than "r ent, ir | e Completed | | | | | | | | | | |
| yland | uld be Mental rrked o | To Be | | NWOOD | | | | ELMA | MERCHA | NT | , | |
| e, Mary | and 2 sho ealth and I n 27 is ma er trauma | • | 19a. Informant's Name/Relations CLAUDETTE DT | | | 7816 | HANOVER | | | | | Code) LAND 20770 |
| Dallimore | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. | | 20a. Method of Disposition 1 Rurial 2 Cremation 4 Donation Other (S | pecify) | | SURREC' | | ETERY 3/2 | | CLINTO | n - City or Tow | LAND |
| 0 | Departing Department Important any ir | | 21. Signature of Funeral Service | Licensee | - | | | oss of Facility J. | | | | 20785 |
| | Physician /Medical | | 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | a. <u>DEMEN</u> | line. ITIA | n. Do not ent | | | | | | Approximate Interval Between Onset and Death |
| | To the Funeral Director. After funeral director, page 2 should be detached for use as the burial-transit or mile in by the funeral director, page 2 should be detached for use as the burial-transit or | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. DIABE Due to (or a HYPE c. Due to (or a | as a consequ CRTENS | ELLITU: uence of): ION | | | | | | |
| .O. DOX | the death certify the attending sched for use as | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknowr | 2 ☐ Fetal t at time of d | death 3 | Ectopic pregnand Other (specify) | y | | | Date of deliver Month [| y Day Year |
| olds, r | quires that en signed build be deta | by | Part II. Other significant condition | ons contributing to death | but not resu | ulting in the ur | nderlying cause giv | en in Part I. | | | | e cause of death? |
| משרו ושו | n: The law re fficate has been or, page 2 sho | e Completed | 25. Was case referred to medical | | | | | | | ormed? 2 □No | o. Were autop: prior to com death? 14 Yes 2 | sy findings available pletion of cause of 2 □¹No |
| 5 | Physicia r this cert ral direct | To B | examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death | Hospital: | | ER/Outpatier | | 4 LI Nursing Ho | ome 5 ☐ Res | | ther (Specify) | t Assist. Living |
| IN SIGN | or Attending fter death. Jirector: Afte in by the fune | Certification: | 1 Natural 5 ☐ Pendin 2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ | g (Month, L gation not be lined 28e. Place of I | Day, Year) | Injury me, farm, stre | Wor | k? Yes 2 □ No | 28f. Location | (Street and Num | | Route Number, |
| ָׁנ | Hospital 24 hours a Funeral E etely filled | edical Ce | 29a. Certifier 1 🔀 Certifyir (Check only one) | ng Physician: To the bea | of examinat | wledge, death | n occurred at the ti vestigation, in my o | me, date and place | , and due to the | e cause(s) and , date and place | manner as sta | ated. the cause(s) |
| . | o the Vithin То the сопр | Me | 29b. Signature and title of certifie | | MD | , | 29c. Licens | e number | | 29d. Date sign | ned (Month, D | |
| • | 84 | | 30. Name and address of person MEKLIT WORKNE | | f death (Item | 23a) (Type, I | Print) | | 4 A D 57 T A 37 | | | |
| | Sta Registra | - 1 | 31. Date filed (Month, Day, Year) | a 32. Regis | strar's Signat | ture | | LENDELI, I | MALILAN | ע 20//0 | | |
| | | | NAR 1 0 2009 | penama | m. 19 | | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| a second | Physicia /Medic Examin Funeral Director | an al er |
|-------------------|---|-------------------------------------|
| ryland 21215-0036 | hould be filed within 72 hours after death with the Maryland id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, it a Medical Exp. offer intertient to it office at | To Be Completed by Funeral Director |

and burial-trar Division of Vital Records, P.O. Box 68760, page 2 should After death.

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2009 5 CAROL J. LAWSON GREEN MARCH 6:11 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) JAN 8 1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Days NEW YORK Hours 1 M 2 X F 64 129-34-1990 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No PRINCE GEORGE'S LANDOVER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20785 USA 1806 KENT VILLAGE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ▼ Married BLACK 1 □Yes 2 □XNo Specify: Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT ATTORNEY 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARLENE MORRISON JOE LAWSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) permit. Pages 1 and 2 sho Department of Health and Anne rtant: If item 27 is ma any intery or other traums once. 19a. Informant's Name/Relationship (Type. Print) Baltimore, Ma 1806 KENT VILLAGE DRIVE LANDOVER, MARYLAND 20785 FREDDIE GREEN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/09 RIVERDALE, MARYLAND RIVERDALE CREMATORY Donation 5 Other (Specify) 21. Signa ure of uneral Serv 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STROKE /Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine HYPERTENSION Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a Was an autopsy performed? Yes 2ὧNo Hospital or Attending Physician: The 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00050951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6310, KENILWORTH AVE, RIVERDALE MD REVA . S. GILL 207 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ours after death.

neral Director: A
filled in by the fu

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ritems 23a or 28a-f shor insermust be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it is it is increased.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

death with the Maryland

| | 23a. Part / Enter the disease, or comp shock, or heart failure. List only of Imme ate Cause (Final dise se or condition | dications that caused the death. Done cause on each line. | o not enter the mode | | | rciano, | Approximate Interval Between Onset and Death |
|---|---|---|--|---|--|---------------------------------------|--|
| Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Respirator Due to (or as a consequence c. Metastasi (Due to (or as a consequence d. Metastatic | e of): / Failur cor Cancer t e of): | e o Lung | | | |
| ysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnent at time of death 9 ☐ Unknown | | | | 23d. Date of de Month | elivery Day Year |
| ed by Pł | Part II. Other significant conditions of | ontributing to death but not resulting | in the underlying ca | use given in Part I. | 23e. Did tobacc 1 ☐ Yes | | o the cause of death? |
| Complete | | | | | 24a. Was an autopsy performed? | prior to death? | utopsy findings available completion of cause of |
| Be (| 25. Was case referred to medical | | | 26. Place of De | ath (Check only one) | | • |
| | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 Inpatient 2 ER/ | Outpatient 3 DO | Other: 4 Nursing | Home 5 ☐ Residence | 6 ☐ Other (Spe | ecify) |
| ation: T | 27. Manner of Death 1 | (Month, Day, Year) | Time of 28 Injury M | ic. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how in | ury occurred | |
| Medical Certification: To | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, building, etc. (Specify) | farm, street, factory, | office | 28f. Location (Street City or Town, Sta | and Number or Fi te) | ural Route Number, |
| edical (| 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | ysician: To the best of my knowled iner: On the basis of examination and manner stated. | ge, death occurred and/or investigation, | at the time, date and place in my opinion, death occ | ce, and due to the cause curred at the time, date a | (s) and manner a and place, and du | as stated. e to the cause(s) |
| M | 29b. Signature and title of certifier | Ł | | License number | | Date signed (Mon | th, Day, Year) |

DHMH 17 Rev 1/2001

JX

State Registrar Goodloes Promise Dr. Bowie, MD. 20720

30. Name and eddress of be son who completed cause of death (Item 23a) (Type, Print)

Mehari

12700

Fischatsion

09-01807 John Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| nn Green | | 1- For State | Sta | te of Maryla | | artment of ertificate of | | nd Me | ntal Hy | | Reg. No. | 200 | 9 11926 |
|--|--|--|-------------------------|-----------------------------------|----------------------|---------------------------------------|----------------------------------|----------------------|------------------------|------------------------|-------------------------|--------------------------------------|---------------------------------------|
| Physicia | ın/ | Registrar 1. Decedent's Name JOHN | e (First, Middle, | Last) | GREEN | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| edical Exami | nteir | 4a. Facility Name (if | f not institution, | give street and nu | | | b. City, Town, | or Location | n of Death | March 3, | | County of Deat | |
| | | 4902 Emo S | | | | | Capitol H | eights | | | | rince Georg | |
| Funeral Director | | 5. Social Security N | 431 | Sex | 7. Age (In yrs. 60 | last birthday) Yrs. | If Under 1 Y | | der 24Hrs. Irs Min. | 8. Date of B | , | Forei | thplace (State or 90 MARYLAND unitry) |
| any | | Usual Residence of 10a. State | Decedent 10b. County | | 10c. City | y, Town or Locati | on | _ | | | | | 10d. Inside City Limits |
| * | _ | MD | PRINCE | GEORGE ' | S | CAPIT | COL HEI | GHTS | | | | | 1 X Yes 2 No |
| Maryland • 28a-f show | Director | 10e. Street and Nur | | | | | 10f. Zip Code | | | | | en of What Cou | ntry? |
| with the Maryland ms 23a or 28a-f sho be notified at once | | 4902 EMO | O STREE | | cedent Ever in U | 18 13 Wa | 2074 s Decedent of | | trigin? / Sn | ecify Vec or N | USA | | ican Indian, Black, |
| death w | Funeral | | ed 2 Marr | | orces? | | es, specify Cul | | | | | White, etc. | real mulan, black, |
| s after c | ã | 3 Widowed | | ced If Yes, Give Yea or Dates: | ar | 1 | Yes 2 X | | | | | Specify: BLA | |
| 2 hours "natu | ted | 15. Decedent's Ed Elementary/Seco | , , | y only highest grad | | 16a. Deceden during me | t's Usual Occu ost of working | | | | 16b. K | ind of Business | Industry |
| 5-0036 led within 7 Hygiene. other than the Medica | Completed | | | | 2 YRS | COI | NSTRUCT | ION W | ORKE | R | PR | RIVATE | |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland pent of Health and Mental Hygene. Intel If item 27 is marked other than "natural", or items 23a or 28a-1 show the other traumatic event, the Medical Examiner must be notified at once | Be Co | 17. Father's Name (| , | ast) EEN | | | | 18.Moth | | (First, Middle | , Maiden S | Surname) | |
| 212 hould be and Ment is mark | 10 E | 19a. Informant's Na | me/Relationship | | | | | | | | | ty or Town, State | |
| ore, MD ss 1 and 2 shoof Health and If item 27 is | | MICKEL GREEN/SON 4902 EMO STREET CAPITOL | | | | | | | | Date Date | | ocation - City o | |
| more, MD 2 Pages I and 2 shou ent of Health and I nt: If item 27 is n | | 1 X Burial 2 | Cremation | 3 Removal fr | om State | crematory or oth VETERAL | ner place) | • | 3/13 | 3/2009 | | • | M, MARYLAND |
| Baltimore, permit Pages 1 and Department of Heal Importment If iten injury or other tra | | 4 Donation 5 21. Signature of Fur | | | | | lame and Addr | | | | ENKIN | IS FUNER | AL HOME |
| | = | 23a Part I Enter th | e disease or co | molications that c | caused the deat | h. Do not enter th | 474 LAN | DOVER | ROAI | D LANDO | OVER. | MARYLAN | D 20785 Approximate Interval |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease complicated by Hypothermia | | | | | | | | | | Between Onset and Death | |
| xaminer | or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | | | |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | | | | | | | | | | |
| | Examine | Colsease or injury that initiated events resulting in death). Last the consequence of the | | | | | | | | | | | |
| 50, te be executed sysician and burial - transit | al E | LINIDEN DED | | d. | | | | | | | | | |
| 60, ate be e hysician e burial | Medical | UNPENDED IF FEMALE: | | AMENDED | outcome of pre | anancv | | | | _ | 23d | . Date of deliver | <u> </u> |
| Box 68760, cath certificate be the attending physical for use as the bur | ian/ | 23b. Was decedent past 12 months | | 1 Live b | | 2 Fe | tal death | 3 Ecto | pic pregna | ncy | | | Day Year |
| Box 6876 ne death certificate the attending phy ned for use as the l | Physician/№ | 1 Yes 2 N | No 9 Unkn | | | oeatri 5 Oti | her (Specify) | | | | | | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial—transity. | by P | Part II. Other signif | | ns contributing to | o death but not | resulting in the u | inderlying caus | se given in | Part I. | | | | the cause of death? |
| ords, w requires s been sig | eted | <u>Diabetes in</u> | TOIITOS | | <u> </u> | | | | | 24a. Wa | s an | 24b. Were a | utopsy findings available |
| of Vital Records, gr Physician: The law require when the contribution of the contribut | Completed | | | | | | | | | per | opsy formed? 2 No | death? | completion of cause of |
| tal Rec | Be C | 25. Was case referr examiner? | red to medical | Hospital: | | | _ | ace of Deat | | | - | | |
| n of Vi ding Physi After this funeral dir | ٢ | | 2 No | | of Injury | ER/Outpatient | | Other | | g Home 5 | | nce 6 🗸 Othe | er: Scene |
| Sion C Attending r death. ector: Af by the fun | tion | 1 Natural | 5 Pendin | | | FOUND: 1712 hrs | 1 | Yes 2 | | | | to environm | ental cold |
| Division Spital or Attendir hours after death. neral Director: A | Certification: | 2 Accident 3 Suicide | 6 Could I | not be 28e. Plac | e of Injury - At I | home, farm, stree | et, factory, offic | e building, | | | | nd Number or R apitol Heights, | ural Route Number, City |
| Hospita 4 hours Fumeral | | 4 Homicide 29a. Certifier | | sician: To the bes | residence | · · · · · · · · · · · · · · · · · · · | red at the time | . date and | | | | | |
| To the Hos within 24 h To the Fur completely | Medical | one) 2 🗸 | Medical Exami | ner: On the basis and manner s | of examination | | ion, in my opir | ion, death | occurred a | | e and pla | ce, and due to t | he cause(s) |
| 10 | Σ | 29b Signature and | title of certifier | \cap \cap | | | 1 | ense numbe C.M.E. | er | | | Date signed <i>(Me</i> ch 4, 2009 | onth, Day, Year) |
| | | 30. Name and addre | ess of person w | ho completed caus | se of death (Ite | m 23a) | | - . | | | I Trical | | |
| To ! | | Patricia Aroi | nica-Pollak | MD. Assista | ant Medical | Examiner | 111 Penn | Street, E | Baltimor | e, MD 212 | 01 | | |
| St Regist | ate rar | 31. Date filed (Mont | th, Day, Year) | 32. Re | egistrar's Signa | parker | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:30 p M Nancy James Haley 2 2009 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mallard Bay Care Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 1, 1 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2X F Yrs. 214-07-8318 94 1915 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show MD Dorchester Cambridge permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f st any InJury or other traumatic event, the Medical Examiner must be notified. 1 ☐Yes 24 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 104 Bayview Avenue 21613 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tyes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕇 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy David James Juanita Parks ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne H. Seabrease daughter 104 Bayview Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge Cemetery 3/6/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** renal week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner accident VOSCUI ON erebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary 2 XNo 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cambrida Bramble 100 32. Registrar's Signature 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Konald Charles 12009 Hazell 10205 AM March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City Town, or Location of Death Examiner Washington Age (In yrs. last birthday) Magersto 5. Social Security Number If Under 1 Year Ψ If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex **Funeral** Year) Months 1942 Maryland 1√ M 2□ F 67 Yrs. 16, Director 218-38-6929 Jan. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shore Examiner must be notified at 1 □Yes 2 No Middletown Director Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21769 7366 Freestate Drive Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ₹ N1964— If Yes, Give Year or Dates: 1965 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 'natural", 7 Is marked other than "natur traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Printing Analyst 18. Mother's Name (First, Middle, Maiden Surname) Mary Williamson 17. Father's Name (First, Middle, Last) Be Robert Hazell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7366 Freestate Drive, Middletown, MD 21769 Health i Patricia Hazell / Wife Department of Health Important: If item 27 any injury or other troops 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Middletown Reformed 3/10/2009 Middletown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 23a.Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. 1100 North Maple Ave., Brunswick, MD 21716 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lerebrovascular accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Examir attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 | Yes 2 | No 3 | Probably 4 | Volknown Completed Mollitus 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 → Yo 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | 1 | 0 1 apatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29b. Signature and title of certifier

State Registrar

tIVa

M.D.

12821

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Wanai

D65488

Oak Hill Ave., Hagestony

| | | Plea | | | | delible Ink. | | | | | _ | le. | | |
|---|-------------------|---|--|--|--------------------------------|---|----------------------------|------------------------|---------------------------------|-----------------------|-----------------------------|---------------------|---|----------------------|
| | | 1 - For State Registrar | State | n warylan | - | tificate of L | | anu iv | ленкаг пу | Reg. N | ~ ~ ~ | 10 | 000 | 200 |
| Dhusi | | Decedent's Name (First, Middle | e, Last) | | | | · · · | · | 2. Date of Do | | 200 | 13 | 3. Time of | Death |
| Physic /Med | | Mary Hall | | | | | | | March | 1 1 | 20 ^Y | 59 | 5:45 | Рм |
| E xam | iner | 4a. Facility Name (If not institution | | imber) | | 4b. City, Town, or | | 40 | c. County of | | | | | |
| F | | 1235 Marlbor | 6. Sex | 7. Age (In yrs. I | ast birthdav) | Lothia If Under 1 Year | | 24 Hrs. | 8. Date of Bi | irth | Anne | | indel ace (State of | Foreign |
| Funera Directo | _ | 217-52-1999 | 1□M 2√2F | | 61 Yrs. | Months Days | Hours | Min. | May 2 | ay, Year 19 | 47 | Mary | land | , or orgin |
| pu , | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | , Town or Lo | cation | | | | | | 140 | d Incido Cit | . I imite |
| faryla shov | 5 | Maryland Anne | Arundei | | thian | | | | | | | 10 | d. Inside Cit1 □ Yes | |
| the N 28a-1 notiff | Directo | 10e. Street and Number | - III dirac | | OHIGH | 10f. Zip Code | | | | 10g. C | itizen of Wh | at Counti | | Λ |
| h with 23a or st be | | 1235 Marlbore | o Rd. | | | 207 | 11 | | | | USA | | | |
| ems a | Funeral | 11. Marital Status | 12. Was Dec Armed F | edent Ever in U.s orces? | S. 13. \ | Was Decedent of His f Yes, specify Cuba | spanic Ori | gin? (Sp | ecify Yes or No Rican, etc.) | 0- | 14. Race - Black. | America White, e | | |
| s after | by Fu | 1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced | ied 1 ☐ Yes If Yes, G | 2 ∏ No ive | | I∐Yes 2√∏No | Specify: | | , | | Specify:] | | | |
| hour tural | | 15. Decedent | Year or I | Dates: | | ient's Usual Occupa | | | | 16b. I | Kind of Busin | | | _ |
| hin 72 | plet | (Specify only highes | st grade completed, | 1-4or 5+) | (Give life. L | kind of work done d DO NOT use retired, | furing mos) | t of work | ing | | | | , | |
| be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | 12th | 0 | | В | us Aid | | | | | nce (| Geor | ge's | Co. |
| be file d oth d oth even | Be | 17. Father's Name (First, Middle, | Last) | | | | | | e (First, Middle | , | n Surname) | | | |
| hould Mer | 은 | Richard Hall 19a. Informant's Name/Relationsl | hip (Tvne. Print) | | 19b. Mailin | g Address (Street a | | | • Hall | | or Town St | ate Zin (| Code) | |
| nd 2 salth ar 27 is r trau | | Mary Hall(Da | | | | Marlbon | | | Lothi | | | | | |
| ss 1 a of Hez | | 20a. Method of Disposition | о ПР I / | | lace of Dispo emetery, crer | sition (Name of natory or other place | e) | I | Date | 20c. l | ocation - Ci | ty or Tow | n, State | |
| Page ment cant: If | | 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | State I . | ews U | .M. Chu | rch | | | | st R | | , Md | • |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. | | 21. Signature of Funeral Service | Licensee | | W | Mame Red Address | of Cacili | Sons | Mort | uar | у, Р. | Α. | | |
| | Pi | 23a. Part1. Enter the disease, or | complications that | Caused the death | | 21 West | | | | | Md. 2 | | | |
| Dhysisian | | shock, or heart failure. List Immediate Cause (Final | only one cause on | each line. | . Do not cine | 1 1 | | | | arrest, | | | Approximate Interval Betw Onset and D | veen eath |
| Physician /Medica | | disease or condition resulting in death) | a. Due to | (or as a consequ | uence of): | heart | arsi | 3 | | | | | | |
| Examine | | Sequentially list conditions, | b. Di | abetes | | e I | | | | | | | | |
| ed sit | xaminer | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to | (or as a consequ | uence o何: | | | | | | | | | |
| executed and al-transit | Exan | that initiated events resulting in death) Last | c | (or as a consequ | uence of): | | | | | | | - | | |
| eath certificate be e attending physician for use as the buria | | | d | | | | | | | | | | | |
| ntifical ng phy | Physician/Medical | IF FEMALE: | | | | | | | | | | | | |
| ath ce | ian/ | 23b. Was decedent pregnant in the past 12 months? | 1□Live | tcome pf pregna birth 2 ☐ Fetal | Ideath 3□ | Ectopic pregnancy | | | | | 23d. Date of | | | 'ear |
| he de | ysic | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 4∐Preç 9⊡Unk | nant at time of de nown | eath 5∟ | Other (specify) | | | | | | | , | |
| that the the the the the the the the the th | | Part II. Other significant condition | ons contributing to | death but not resu | ulting in the ur | nderlying cause give | en in Part I | | 23e. Did | tobacco | use contrib | ute to the | cause of de | eath? |
| quires an sign | ed by | | | | | | | | 1 🗆 | Yes 2 | 2 □ No 3 | ☐ Proba | bly 4 🗹 U | nknown |
| iaw re as bee 2 sho | plet | | | | | | | | 24a. Was | DDSV | 24b. We | ere autop | sy findings a | available ause of |
| The cate h | Completed | | | | | | | | perf 1□ Yes | formed? 2 N | dea | ath? | No | |
| iclan certific | Be | 25. Was case referred to medica examiner? | Hospital: | | | Othe |).F' | | h (Check only | | | | | |
| Phys | ٠ <u>.</u> | 1 Yes 2 No 27. Manner of Death | 28a. Date | of Injury | ER/Outpatier 28b. Time of | I SU DOA | 4 🗆 NU | | ome 5 Res 28d. Describe | | | . , ., | | |
| ath. r: Afte | ation | 1 Natural 5 ☐ Pendin 2 ☐ Accident investig | g i | nth, Day Year) | Injury | | k? Yes 2□ | No | | | | | | |
| r Atte er deg recto | Certification: | 3 Suicide 6 Could determ | ined 28e. Plac | e of injury - At ho ding, etc. (Specif) | me, farm, str | eet, factory, office | | | 28f. Location City or To | | | or Rural | Route Numi | ber, |
| vital o urs aft eral Di | - | | | | | | | - 1 - 1 | | | '-\I | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical | 29a. Certifier Check only one) Certifyir (Check only one) | ig Physician: 10 the Examiner: On the and ma | basis of examination basis of examination of examination of examination of examination of the basis of the ba | tion and/or in | n occurred at the tin vestigation, in my o | ne, date ar pinion, dea | nd place, ath occur | red at the time | e cause(e, date a | s) and manr nd place, an | d due to | ited. the cause(s |) |
| To the within To the | Me | 29b. Signature and title of certifie | r -01 | 7 | | 29c. License | e number | | | 29d. D | ate signed (| Month, D | ay, Year) | |
| 2 | .15 | John to | . will | 4 ms | | D0050 | 5389 | i M | kary kind | - | 3/4 | 100 | 1 | |
| 3/19 | ,,,,,, | 30. Name and address of person | who completed car | ise of death (Item | 23a) (Type, | 29c. License DDD 50 Print) A Mar | -14. | 200 | 01, 1 | lno | . M. | 11 | mD. | דרוש |
| | tate | 31. Date filed (Month, Day, Year) | 32. | Begistrar's Signa | ture | JICK IN WI | ייפו | 10 | TIKE | 7 | 44101 | 1964 | | |
| Regis | | MAR 09 | 2009 | mer ! | A. 6. | will | | | | | | | | |
| | 10004 | | 100 | | 7 | | | | | | | | | |

Registrar DHMH 17 Rev 1/2001

| 09-01822 Robert M. Holme | ·c S | Please Type or Print in Black Inde | lible Ink. Ensure All Copie nent of Health and Mental Hy | s Are Legi | ble. | |
|--|----------------|---|--|-----------------------------|--|--|
| Nobelt W. Hollie | | I- For State Certific | cate of Death | Reg. | No. 200 | 9 092 |
| Physicia | ın/ | 1. Decedent's Name (First, Middle,Last) | | 2. Date of Death | | . Time of Death |
| Medical Examin | | Robert M. Holmes, Sr. | 4b. City, Town, or Location of Death | March 4, 20 | 09 4c. County of Death | 1105 hrs |
| · Comment of the comm | | 4a. Facility Name (if not institution, give street and number) 7318 Lanham | Fort Washington | | Prince George's | 3 |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last b | irthday) If Under 1 Year If Under 24Hrs Months Days Hours Min. Yrs. | - | MM/DD/YYYY) 9. Birthr Foreign Coun | Washingto |
| | ŀ | Usual Residence of Decedent | | | | 0d. Inside City Limits |
| I low any | | 10a. State 10b. County 10c. City, Tov MD Prince George's | on or Location Fort Washington | | | 1 Yes 2 X No |
| aryland | Director | 10e. Street and Number | 10f. Zip Code | 10g | . Citizen of What Countr | y? |
| the M Sa or 2 | | 7318 Lanham Lane | 20744 | | USA | |
| r death with the Maryland or items 23a or 28a-f show must be notified at once. | Funeral | 11. Marital Status 1 Never Married 2 Married Armed Forces? | 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | | 14. Race - America White, etc. | an Indian, Black, |
| fter dez | | 3 Widowed 4 Divorced If Yes, Give Year | 1 Yes 2 X No specify: | | Specify: Whi | ite |
| 2 hours after "natural", | od by | | a. Decedent's Usual Occupation (Give kind of v | work done 1 | 6b. Kind of Business/Inc | dustry |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | Handyman | | Constructi | ion |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical | | 17. Father's Name (First, Middle, Last) | | e (First, Middle, Ma | | |
| 121 Id be fi Aental narked event, | o Be | Richard A. Holmes Sr. 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing Address (Street and Number or I | | | Zip Code) |
| AD 2 2 shou h and N 27 is n imatic | 10 | Carey H. Bowen/Daughter | 201 Stratford Drive | | al Beach, V | |
| re, N i l and f Healtl if item er trau | | | re of Disposition (Name of cemetery, natory or other place) | 107 12000 | 20c. Location - City or T | |
| imo Pages ment o fant:] | | 4 Donation 5 Other Specify: Bay | - Cranacory | | Baltimore, | Maryland |
| Balt permit. Departi Importinjury | | 21. Signatu a of Fund al Succe Licent e | 22. Name and Address of Facility E | | eral Home | |
| Physician | Н | 23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line. | not enter the mode of dying, such as cardiac of | or respiratory arres | t, shock, or heart | Approximate Interva Between Onset and |
| Medical | | Immediate Cause (Final disease a. Narcotic (Heroin) and Coc | aine Intoxication | | | Death |
| | | or condition resulting in death) Due to (or as a consequence of): | | | 5 | |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | |
| recuted 1 and 1 transit | | d. | | | | |
| 30, te be ex ysician burial | ledic | UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnan | CV | | 23d. Date of delivery | |
| Box 68760, e death certificate be the attending physic ed for use as the bur | ian/Medical | 23b. Was decedent pregnant in the past 12 months? | 2 Fetal death 3 Ectopic pregn | ancy | Month Da | ay Year |
| SOX death of the attention us | Physici | 1 Yes 2 No 9 Unknown g Hearth Unknown | 5 Other (Specify) | | | |
| O. Enat the order by the etached | | Part II. Other significant conditions contributing to death but not resu | Iting in the underlying cause given in Part I. | | acco use contribute to the | |
| S, P. uires th | ed by | | | 1 Yes | 2 ✓ No 3 Proba | opsy findings availabl |
| cord law req has bee | Completed | | | autops: perform | y prior to co ned? death? | empletion of cause of |
| Rec The ficate | | 25. Was case referred to medical | 26 Place of Death (Check | 1 Yes 2 | No 1 ✓ Yes | 2 No |
| /ital | o Be | examiner? | Othor | | tesidence 6 🗸 Other: | Scene |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | - | 27. Manner of Death 28a. Date of Injury 28 | Bb. Time of Injury 28c. Injury at Work? OUND: 1 Yes 2 V No. | 28d. Describe ho Unknown | ow injury occurred | |
| Sion Attendidenth death ector: | catio | 2 Accident Investigation Mar 4, 2009 1 | OUND: 1 Yes 2 No No No farm, street, factory, office building, etc. | 28f Location (St | reet and Number or Rur | al Route Number, City |
| Divis | Certification: | Suicide 6 Could not be determined (Specify) Single Family | | or Town, Sta | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, | death occurred at the time, date and place, an | d due to the cause | (s) and manner as state | d. |
| To the within. To the comple | Medical | one) Wedical Examiner: On the basis of examination and and manner stated. | or investigation, in my opinion, death occurred 29c. License number | at the time, date a | nd place, and due to the 29d. Date signed (Mon | |
| | Σ | 29b. Signature and title of certifier | O.C.M.E. | | March 6, 2009 | as, Day, rear |
| argu |) | 30. Name and address of person who completed cause of death (Item 23 | da) | | | |

31000

State 31. Date filed (Month, Day, Year)
Registrar MAR 0.9 2009

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Laron Locke MD. Assistant Medical Examiner

09-02172 Aron Scott Hawks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 0 | 0 | \cap | 0 | 0 | \cap | 2 | 7 |
|---|---|--------|---|---|--------|---|---|
| 2 | U | U | 7 | U | 7 | 4 | 7 |

| | 1- For State Registrar | Certificate of | Death | Re | g. No. | 0) = 1 | |
|---|--|---|---|--|---|-------------------------------------|--|
| Physician/ dedical Examine | Decedent's Name (First, Middle,Last) | ott Hawks | | 2. Date of Death Month March 17, | Day Year 400 | e of Death B7 hrs | |
| | 4a. Facility Name (if not institution, give street and numb Parallel with Biddle Street | | 4b. City, Town, or Location Chesapeake City | n of Death | 4c. County of Death Cecil | · | |
| Funeral | | Age (In yrs. last birthday) | If Under 1 Year If Un | nder 24Hrs. 8. Date of Birt | h(MM/DD/YYYY) 9. Birthplace | (State or | |
| Director | 175-52-7218 1XM 2_F | 35 Yrs | Months Days Hou | JAN 13 | Foreign Country)M | aryland | |
| , | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Locat | ion | | 10d. In | side City Limits | |
| Maryland 28a-f show any d at once. | W 1 1 C 11 | Cecilton | | | | Yes 2 No | |
| the Maryland a or 28a-f sh iified at once | 10e. Street and Number | | 10f. Zip Code | 10 | 10g. Citizen of What Country? | | |
| th the Maryland 23a or 28a-f she notified at once | | | 21913 | | United State | | |
| after death with the Maryland "al", or items 23a or 28a-f sh iner must be notified at once ov Funeral Director | 11. Marital Status 1 Never Married 2 X Married 12. Was Deced | es? If Y | es, specify Cuban, Mexic | | 14. Race - American Indi White, etc. | an, Black, | |
| rall", on liner m | 2 Midowod A Divorced III Tes, Give real | 1 | Yes 2 X No speci | ify: | Specify: White | | |
| xam | | during m | nt's Usual Occupation (Givenost of working life, DO NO | | 16b. Kind of Business/Industry | | |
| 36 In 72 l han "1 lical E | Elementary/Secondary (0-12) College (1-4 | | | | Pet Care | | |
| 5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examine Completed by | 12 17. Father's Name (First, Middle, Last) | GIO | omer 18.Motr | her's Name (First, Middle, M | | | |
| 215. De filec nital Hy ent, the ent, the Cont. | | | Sa | rah Engelson | | | |
| 21. ould b ould b d Men s mar | 19a. Informant's Name/Relationship (Type, Print) | | g Address (Street and N | Number or Rural Route Num | ber, City or Town, State, Zip Co | ode) | |
| MD d 2 sh ith and ith and in 27 it | Nicole Hawks/Wife | | | | on, MD 21913 | Chata | |
| Baltimore, MD 21215-Q036 permit. Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n injury or other traumantic event, the Medical E To Be Complete | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from | State Gilpin Ma | sition (Name of cemetery, ther place) | March 20, | Elkton, MD | state | |
| litin nit. P. artme oortan ry or | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee | Memorial | Name and Address of Fac | r Funerals, | | | |
| Perra Perra Injection | Kristen Hill Cum | n a | J3 W. Stockt | on Street. E | Ikton. MD 219 | 21 | |
| Physician | 23a. Lart I. Enter the disease, or complications that cau failure. List only one cause on each line. | sed the death. Do not enter | the mode of dying, such a | s cardiac or respiratory arre | est, shock, or heart Appr Betv | roximate Interval ween Onset and | |
| /Medical caminer | Immediate Cause (Final disease a. Alcohol | l and Benzodi | azepine use hermia | complicated | by | Death | |
| | Sequentially list conditions, b. | | | | | | |
| | if any, leading to immediate Due to (or as a c cause. Enter Underlying Cause | onsequence of): | | | | | |
| - Z | Due to (or as a c | | | | | | |
| and - transit | d. | 23a,27,28a-f, | perMF c880 | 3/26/09 TT | | | |
| 760, icate be execution by physician and the burial - tra | XUNPENDED AMENDED | | periil, goos | 3/20/07 11 | 23d. Date of delivery | | |
| 8760, iificate be ng physici as the burn | IF FEMALE: 23c. If yes, or 1 Live bir | utcome of pregnancy | etal death 3 Ect | opic pregnancy | Month Day | Year | |
| Box 68 certification attending certification by series as it is a | past 12 months? 4 Pregnar 7 1 Yes 2 No 9 Unknown | nt at time of death 5 C | other (Specify) | | | | |
| h. Box 68 the death certif by the attending ched for use as | Part II. Other significant conditions contributing to a | | underlying cause given in | Part I 23e Did to | obacco use contribute to the cau | use of death? | |
| Division of Vital Records, P.O. But and requires that the de transfer death. The Inverted After this certificate has been signed by the led in by the funeral director, page 2 should be detached for this certification. To Be Completed by Dhy | | Jean but not resulting in the | andenying dadac giverni | | s 2 No 3 Probably | | |
| duires en sig | | | · · · · · · · · · · · · · · · · · · · | 24a. Was | | | |
| Records, The law requires ficate has been sig | | | | | rmed? death? | | |
| tal Rection: The certificate ector, page | 5 | | 26 Place of Do | 1 Yes | 2 No 1 Yes | 2 No | |
| ician: | examiner? Hospital: | patient 2 ER/Outpatier | Other | | Residence 6 V Other: Scene | e | |
| of Viling Physic | 27 Manner of Death 28a, Date o | f Injury 28b. Time of | | Vork? 28d. Describe | how injury occurred | | |
| on C anding tth. rr: Af he fun | 1 Natural 5 Pending F.d. 3 | Day, Year) /17/09 Fd 4: | 25 pm 1 Yes 2 | X No | re to low envir rature | onmental | |
| r Atte ter der der irecto | 2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place | Street and Number or Rural Rou State) Biddle St. | ite Number, City | | | | |
| Divisior Bospital or Attend 24 hours after death Funeral Director: tely filled in by the | Homicide determined (Specify) field Chesapeake City, MD | | | | | | |
| 흥골품질 5 | | examination and/or investig | urred at the time, date and ation, in my opinion, death | d place, and due to the caus h occurred at the time, date | se(s) and manner as stated. and place, and due to the caus | e(s) | |
| To the within 7 To the complet | and manner sta | ated. | 29c. License num | ber | 29d. Date signed (Month, Da | y, Year) | |
| | (12 DE 1/10) | 0 an | O.C.M.E. | | March 18, 2009 | | |
| | 30. Name and address of person who completed cause | e of death (Item 23a) | | | | | |
| | Carol Allan, MD Assistant Medical E | xaminer 111 Penn | Street, Baltimore, I | MD 21201 | | | |
| Stat | MAN & TANKS | gistrar's Signature | ned | | | | |
| Registra | | 0 .63 | | | | | |

OCME

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Thelma Irene JACKSON March 11, 1:05 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Nursing Home Williamsport Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 217-10-2852 88 Director July 10, 1920 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it he Modical Examinat must be notified at any pines. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Williamsport Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue Apt. B113 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ white 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Sigler 2 Mary Lucinda Lynn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Long - daughter 214 Alexander St., Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 3/16/09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Finel Physician diseese or condition resulting in death) Chronic obstructive. pulmonary disease Vears /Medical Due to (or as a consequence of): Examiner second-hand smoke EXPOSURE to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last years Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by atherosclerotic heart 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has director, page 2 a autopsy 1 ☐ Yes 2 NO 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 ☐ Pending investigation I hours after death, uneral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a vithin 24 hours a To the Funeral Completely filled in the comp 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 28 Cynthia Kuther-Sands so March 11,2009 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Virginia Avenue, Williamsport Maryland CYNTHIA Kuttner-Sands, mp 16505 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 12 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Year 9 **Physician** 04:52 PM LRA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB 17 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1\XM 2□ F Months Days Hours Min 577-68-2945 1950 WASHINGTON, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Evariner must be notified at once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director SILVER SPRING MONTGOMERY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14025 WAGON WAY 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐Yes 2 ☐No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLASSIFICATION SPECIALIST GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSETTE HARROD ၉ JOHNSON SR. TRA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 DELRIA R. JOHNSON/WIFE 14025 WAGON WAY SILVER SPRING, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 3/10/2009 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Fune I Service Licersee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1yocaraig disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner ardiac if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physlcian: The law requires that the death certificate be executed +Nox(c and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ed by the 9 Unknown 9 Unknown signed by be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a Was an page 2 s has certificate 1 ☐Yes 2 No this certificant al director, p 25. Was case referred to medica examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Dr. Cheverly Atkham-300 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

| | | | For 1 _ State | | State of Ma | aryland | | | | Mental H | ygiene | 000 | 09275 |
|----------------|---|---------------------|---|--|---|-------------------------------------|--------------------------|---|--|--|-------------------------------------|---|---|
| | | | Registrar 1. Decedent's Name (First | t Middle Last | 1 | | Cei | rtificate of | Death | 2. Date of D | Reg. No. | 009 | |
| | Physici | | ARCHI | | , | KING | | | | Month MARCH | Day | 2009 | 3. Time of Death 3:20 A M |
| No. of Street, | /Medic Examin | | 4a. Facility Name (If not in | | street and number) | 102110 | | 4b. City, Town, o | Location of De | | | ounty of Death | |
| 1 | | | | AINDRO | | | | GLENBU | | | | NNE ARU | NDEL |
| | Funeral Director | | 5. Social Security Number 416–52–3390 | | XM olle | e (In yrs. las 66 | t birthday) Yrs. | If Under 1 Year Months Days | If Under 24 H Hours Mi | | irth <i>9ay, Year)</i> 3 1942 | Cou | place (State or Foreign http:// AMA |
| | TO | | Usual Residence of Deced | ient County | | 10c. City, 7 | Tauwa au 1 a | antin a | | | | | |
| | f sho | or | | NE ARU | MINET | | N BUI | | | | | | 10d. Inside City Limits 1 1 Yes 2 □ No |
| | r 28a- | irec | 10e. Street and Number | NE ARO. | MDEL | GLE | N DOI | 10f. Zip Code | | | 10g. Citize | en of What Cour | |
| | th with | ralD | 415 RAINDRO | P COUR | Т # Е | | | 21061 | | | USA | | |
| 215-0036 | be flied within 72 hours after death with the Maryland Hylgiene. d other than "natural", or items 23a or 28a-f show event, the Andical Eventimer must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2[3 □ Widowed 4 ☒ Di | | 12. Was Decedent I Armed Forces? 1 Tyes 2 And If Yes, Give Year or Dates: | | 1 | Was Decedent of H fYes, specify Cuba I □Yes 2 No | ispanic Origin? In, Mexican, Pu Specify: | (Specify Yes or Nerto Rican, etc.) | | I. Race - Americ Black, White, Specify: | |
| 2 | 72 hc "natur | letec | 15. De (Specify only | ecedent's Edu y highest grad | cation e completed) | | 6a. Deced | dent's Usual Occup kind of work done o OO NOT use retired | ation furing most of w | rorking | 16b. Kind | of Business/In | dustry |
| 717 | within ene. than' | Completed | Elementary/Secondary (| (0-12) | College (1-4or 5 | +) | | OO NOT use retired ENTENANCE | | | | PRIVATI | £ |
| D | | Be C | 17. Father's Name (First, M | Middle, Last) | | | | | | ame (First, Middle | e, Maiden St | | |
| yland | 2 should be and Mental is marked o aumatic eve | 70 E | UNKNOWN | • | | | | | MA | GNOLIA | GREE | N | |
| 5 | ~ = > = = | | 19a. Informant's Name/Re JOANN KING | Interpretation (T) | | | 19b. Mailin 1309 | g Address (Street INLAND D | and Number or RIVE DI | Rural Route Num STRICT H | ber, City or 1 EIGHTS | Town, State, Zip 5 , MARY LA | AND 20747 |
| Hore | permit. Pages 1 and Department of Heali Important: If item 2 an viury or other once. | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ ○ | nation 3 🗆 F | Removal from State | 20b. Plac cem WASH | e of Disposetery, crem | sition (Name of natory or other plac NAT L | _{e)} 3/1 | Date 2/2009 | i | ation - City or To | |
| Battimol | permit. Departn Importa an oit | | 21. Sign Aure of Fyneral S | Sirvice Licens | ee | | | Name and Address | | J. B. JE | | | |
| | | | 23a. Part 1. Enter the dise shock, or heart failur | ease, or compl | ications that caused | the death. | | | | | | IAKT DANI | Approximate Interval Between |
| F | hysician | | Immediate Cause (Final disease or condition | c. List only of | | | OLON | CANCER TO | LIVER | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | | Due to (or as | a consequen | ice of): | | | | | | |
| H, | | er | Sequentially list conditions if any, leading to immediate | s, le | Due to (or as | a consequen | ce of): | | | | | - | |
| | ecuted nd transit | Examiner | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 1 | o | | | | | | | | |
| 0/00 | ricate be executed physician and s the burial-transit | al Ex | resulting in death) Last | ı | Due to (or as a | a consequen | ce of): | | | | | | |
| 00 | g phys | edical | | | i | | | | | | | | |
| . DOX | Prystotan: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnatin the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | anı | 3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal de | ath 3 | Ectopic pregnancy | , | | 23 | d. Date of delive Month | ery Day Year |
| us, r | to the hospital of Attending Prystotan: The law requires that the or the tot the 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | ρ | Part II. Other significant c | conditions co | ntributing to death bu | ıt not resultin | ig in the un | derlying cause give | en in Part I. | | | | ne cause of death? |
| ecords, | raw requ | Completed | | | | | | | | 24a. Was | an | 24b. Were auto | psy findings available mpletion of cause of |
| ומ ומ | r: Ine ficate r, page | | | | | | | | | 1 □Yes | ** | death? 1 ☐ Yes | 2 🙀 No |
| = | siciar s certii irecto | Be | 25. Was case referred to n examiner? 1 ☐ Yes 2 🖾 No | _ | lospital: | nt 2□ER | Outpotion | Othe | \r' | eath <i>(Check only</i> Home 5 A Res | | 700 45 4 | |
| 5 2 | ig rny ter this neral d | n: To | 27. Manner of Death | D. C. | 28a. Date of Injur | y 28 | b. Time of Injury | | | 28d. Describe | | 1-1 | y) |
| | eath. or: Af the fur | catio | 2 Accident | Pending investigation Could not be | | | | M 1 🗆 | res 2 □ No | | | | |
| 2 | al or At s after d il Direct ed in by | Certification: | | determined | 28e. Place of Inju building, etc | ry - At home :. <i>(Specify)</i> | , farm, stre | eet, factory, office | | 28f. Location City or To | (Street and I wn, State) | Number or Rura | l Route Number, |
| | re nospir | Medical (| 29a. Certifier 1 ☑ Co (Check only one) 2 ☐ M | ertifying Phy edical Exami | sician: To the best of ner: On the basis of and manner sta | examination | dge, death and/or inv | occurred at the tir vestigation, in my o | ne, date and pla pinion, death oc | ce, and due to the curred at the time | e cause(s) a , date and p | nd manner as s lace, and due to | stated. the cause(s) |
| | To the comp | ž | 29b. Signature and title of | certifier | (| | | 29c. License | number | | 29d. Date s | signed (Month, | Day, Year) |
| | 5 | | | latil | der H. | >ce / | ms | | 6250 | | 31 | 3/200 | 9 |
| - | A. | | 30. Name and address of p | | | | | | RGO, MAI | RYLAND : | 20774 | | |
| P | Sta | | 31 Date filed (Month, Day, | Year) | 32 Registra | r's Signature | , | | | | | | |
| | Registra | ar | wan 1 | 0 2009 | Bestin | B. | 900 | | | | | | |

| | | | 1 - For State Of M Registrar | | artment of Healtr rtificate of Deati | | al Hygie: Reg. | ne No2009 | 09276 |
|-----------------------|--|----------------|--|---|---|--|---|---|--|
| | Physicia | | 1. Decedent's Name (First, Middle, Last) Thelma Louise LaBriola | | | | ate of Death looth arch 1, | Day 2009 Year | 3. Time of Death 6:15 p м |
| 1 | /Medic Examin | | 4a. Facility Name (If not institution, give street and number, 9706 Prince William Drive | | 4b. City, Town, or Location Brandywine | on of Death | | 4c. County of Death | |
| Ī | Funeral Director | | 5. Social Security Number 6. Sex 7. Ag 1 M 2 T F 8 | ge (In yrs. last birthday) 39 Yrs. | | ler 24 Hrs. 8. D. | ate of Birth Month, Day, Yeune 9,1 | | nplace (State or Foreign untry) |
| | yland now | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | 8a-fsh | Director | MD Prince George | Brandywin | | | | | 1 □Yes 2X No |
| | th with the 23a or 2 | ral Dir | 10e. Street and Number 9706 Prince William Drive | | 10f. Zip Code 20613 | | 10g. | Citizen of What Col | untry? |
| 9800 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if it is it collects for viit at must be 1 officed at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Arreed Forces 1 □ ☑ Yes 2 □ If Yes, Give Year or Dates: | No 1 0/13 | Was Decedent of Hispanic 0 If Yes, specify Cuban, Mexic 1 □Yes ※ No Specif | | es or No- , etc.) | 14. Race - Ame Black, White Specify: Wh | ican Indian, , etc. lite |
| 15-0 | in 72 ho n "natu l'o ficel | Completed | 15. Decedent's Education (Specify only highest grade completed) | (Give | dent's Usual Occupation kind of work done during me DO NOT use retired) | ost of working | 16b | . Kind of Business/I | ndustry |
| 212 | ed with lygiene ner thau | | Elementary/Secondary (0-12) College (1-4or 12) | 5+) | 1 Bus Driver | | | Pransporta | ation |
| and | ld be fil lental H ked oth ic even | To Be | 17. Father's Name (First, Middle, Last) Daniel T. Long | | | ther's Name <i>(Firs</i> nnie B. | t, Middle, Maid $\operatorname{Becht1}$ | , | |
| , Maryland 21215-0036 | and 2 shouealth and N n 27 Is mai | | 19a. Informant's Name/Relationship (Type. Print) Kenneth LaBriola (son) | | ng Address (Street and Num Prince Willi | | | | |
| nore | Pages 1 ann of He nort of He nort of the nort of the north or oth | | 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | March 11 | | Location - City or 1 | |
| Baltimore, | permit. Page Department Important: I any injury of once. | | 21. Signatur Funeral Service Licensee | M01464 22 | ans Cemetery | cility Lee Fu | uneral | Home Calv | |
| | · · | - | ohn F. Holn 23a, art 1. Enter the disease, or complications that cause | | 125 Southern | | | Owings, | MD 20736 Approximate |
| | Physician /Medical | | shock, or heart failure. List only one cause on each life mediate Cause (Final isease or condition resulting in death) | ne. # STATIC a consequence of): | BRIEAST | - 1 | | | Interval Between Onset and Death |
| 0.00 | Examiner | <u>-</u> | Sequentially list conditions, b. | a consequence of. | | | | | |
| | ecuted ind transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events c | | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | edical Ex | resulting in death) Last Due to (or as | a consequence of): | | | | | |
| | | /Med | IF FEMALE: 23c. If yes, outcome | of pregnancy | | _ | | 00d D-4f d-15 | |
| .O. Box | that the death ned by the atter detached for u | Physician/M | | 2 Fetal death 3 | | | 23d. Date of deli Month | very Day Year | |
| Records, P. | The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use | þ | Part II. Other significant conditions contributing to death b | ut not resulting in the ur | nderlying cause given in Par | rt I. 2 | 23e. Did tobacco use contribute to the cause of death 1 □ Yes 2 10 No 3 □ Probably 4 □ Unkn | | |
| _ | : The law recate has be page 2 sho | Completed | | · | | | 4a. Was an autopsy performed □Yes 2 | prior to c death? | opsy findings available ompletion of cause of 2 □ No |
| Viital | siclan: The certificate irector, pag | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpati | | Othor: | ace of Death (Che | ck only one) | | |
| Division of | nding Phy th. : After this e funeral d | | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | ent 2 ER/Outpatier ury 28b. Time of Injury | 11 3 DOA 4 1 | 28d. D | escribe how in | e 6 ☐ Other (Special of the following occurred) | ify) |
| DIVIS | e Hospital or Attending Physiclan: 124 hours after death e Funeral Director: After this certifical letely filled in by the funeral director; | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or a City or Town, State) | | | | | | |
| | e Hospii 24 hour e Funer letely fill | Medical | 29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st | of examination and/or in | h occurred at the time, date vestigation, in my opinion, d | and place, and di death occurred at | ue to the caus the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of certifier | | 29c. License number | 9/1 | 29d. | Date signed (Month | , Day, Year) |
| | 01. | | 30. Name and address of person who completed cause of c | , , , , , | , | 100 | | 7/0 | / |
| KV | 8+1 Sta | te_ | Dr. Louis Kaufman, M.D. 120' 31. Date filed (Month, Day, Year) 32. Registr | 70 Old Line | Centre Suite | e 207 Wa | ldorf N | AD 20602 | · |
| | Registra | | MAR - 6 2hng | The same of the same of | have 1 | | | | |

| | | Pleas | se Type or Prin | | | | | - | _ | ble. | | | |
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| | | Registrar 1. Decedent's Name (First, Middle, | | | 00, | imouto or i | | 2. Date of Dea | ith | 3. Time of Death | | | |
| Physici /Medio | | Wade Albertus L | JUM | | | | | March | | 2009 7:23 M | | | |
| Examir | ier | 4a. Facility Name (If not institution, Washington Coun | _ | | | | r Location of Death Prstown | | 4c. County | of Death .shington | | | |
| Funeral | | | 6. Sex 7. Age | | ıst birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day | n | Birthplace (State or Foreign Country) | | | |
| Director | | 217-18-7305 | 13K1 M 2□ F 8 | 6 | Yrs. | Months Days | Hours Min. | April 5 | , 1922 | _Maryland | | | |
| /land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | , Town or Lo | cation | | | | 10d. Inside City Limits | | | |
| e Mary 3a-f sh Uffied | ctor | Maryland Wash | nington | | Hag | erstown | | | | 1 □ Yes 2X No | | | |
| If E. 12.13.0000 filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exemples must be notified at | Directo | 10e. Street and Number 17214 Gay Stre | 2e+ | | | 10f. Zip Code | 21740 | 1 | 10g. Citizen of V USA | Vhat Country? | | | |
| ms 23 | Funeral | 11. Marital Status | 12. Was Decedent B | Ever in U.S | i. 13.) | Was Decedent of H | | pecify Yes or No- | | e - American Indian, | | | |
| or ite | | 1 ☐ Never Married 2 🛣 Marrie | If Vac Give | | | iYes, specity Cuba 1 ∐Yes 2⊠ No | Specify: | Hican, etc.) | Blac Specify | k, White, etc. : white | | | |
| hours tural" | ed by | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's | Year or Dates: | 942-4 | | dent's Usual Occup | ation | | | Isiness/Industry | | | |
| thin 72 ee. | Completed | (Specify only highest Elementary/Secondary (0-12) | t grade completed) College (1-4or 5 | +) | (Give life. L | kind of work done of DO NOT use retired | during most of work d) | king | | | | | |
| iled wil Hygien ther th | | 8 17. Father's Name (First, Middle, L. | 0 | | sneet | metal me | 18. Mother's Nam | o (First Middle | | aft mfg. | | | |
| d be fi ental h ked ol | To Be | Hoye A. Lum | asij | | | | | e Pitten | | θ) | | | |
| 2 should be and Mental is marked or raumatic ever | - | 19a. Informant's Name/Relationshi | | | | ng Address (Street | | | | | | | |
| 1 and 1 Health em 27 ther tr | | Geraldine Lum - | · wife | 20h Blo | | 4 Gay Str | | | | nd 21740 City or Town, State | | | |
| Pages 1 | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Specific Specific Spe | | | | sition (Name of matory or other place on Cemete: | | | | own, Maryland | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exemples must be notified at once. | | 21. Signature of Funeral Service L | | | | 2. Name and Addres | | INNICH I | | • | | | |
| 28 E 28 | | South | Thy Dus | me | | | son_Blvd. | , Hager | stown, l | Maryland 21740 | | | |
| | | 23a. Part T. Enter the disease, or on shock, or heart failure. List on Immediate Cause (Final | only one cause on each lin | ie. | | er the mode of dyin | ng, such as cardiac | or respiratory arr | rest, | Approximate Interval Between Onset and Death | | | |
| Physician / / / / / / / / / / / / / / / / / / / | | disease or condition resulting in death) | a. Due to (or as | | | 3,,00 | 0 | | | | | | |
| Examiner | | Sequentially list conditions | b | 10 h | 1-1 | Ju | +a~.! | | | | | | |
| ted nsit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | | | relove | A. | Than | il vola | ٠. | | | |
| be executed ician and burial-transit | Exar | that initiated events resulting in death) Last | c. Due to (or as | | ence of): | | | | | | | | |
| anth certificate be er attending physician for use as the buria | lical | | d | | | | | | | | | | |
| certific ding p | /Mec | IF FEMALE: | 23c. If yes, outcome | of pregnan | ncv | | | | | | | | |
| The law requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the t | Physician/Medica | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1 ☐ Live birth 4 ☐ Pregnant a | 2 Fetal | death 3 | Ectopic pregnanc Other (specify) | у | | Mo | e of delivery nth Day Year | | | |
| at the de | hys | 9 🗆 Unknown | 9 ∐ Unknown | | | | | 1 | | | | | |
| ires tha signed | þ | Part II. Other significant condition | ns contributing to death bu | ut not resul | Iting in the ur | nderlying cause give | en in Part I. | | | ibute to the cause of death? 3☐ Probably 4★★Unknown | | | |
| w requii | Completed | | | | | | | 24a. Was a | | Were autopsy findings available | | | |
| The lar | ошо | | | | | | | autops perfori | sy p med? d | orior to completion of cause of leath? | | | |
| cian: ertifica ector, p | Be C | 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | | 1 | 165 2 110 | | | |
| Physic this c | ۲: | 1 ☐ Yes 2 ☐ No 27. Manner of Death | Hospital: 1 Inpatie | | ER/Outpatier | ot 3 DOA Oth | 4 Li Nuising H | ome 5 Residence | | | | | |
| nding ath. r: After e fune | ation | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga | (Month, Da) | y, Year) | Injury | Work | yat k? Yes 2 □ No | 200. Describe III | ow injury occurr | e u | | | |
| or Atte ter deg irector | Certification | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | | ury - At hon | ne, farm, str | eet, factory, office | | 28f. Location (Si City or Town | cation (Street and Number or Rural Route Number, ty or Town, State) | | | | |
| pital o | | 29a. Certifier 12°Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | anner as stated | | | |
| To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page | Medical | (Check only one) Medical E | xaminer: On the basis of and manner sta | f examinati | ion and/or in | vestigation, in my o | ppinion, death occu | rred at the time, o | date and place, | and due to the cause(s) | | | |
| withi Jott | Me | 29b. Signature and title of certifier 29c. License number | | | | | | | 29d. Date signed (Month, Day, Year) | | | | |
| JA | | 20. Name and address of parent | who completed earlies of d | ooth /lte- | 02a) /Time | Print) | 707 | | 5.11 | 201 | | | |
| 10x' | | 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prafull Control (Item 23a) (Type, Print) Prafull (Item 23a) (Type, Print) Prafull (Item 23a) (Type, Print) Prafull (Item 23a) (Type, Print) | | | | | | | | | | | |
| Sta Registr | ite | 31. Date filed (Month, Day, Year) | 2000 32. Registra | ar's Signatu | ure | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3 2009 9:50 p. March Maurice Cullen Lewis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 109 Talbot Avenue Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Feb. 25, 1926 Maryland 215-20-1146 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Cambridge Yes 2 No MD Dorchester Director death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 109 Talbot Avenue 21613 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinar 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) attorney law 5+ 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Etta Fleming Maurice C. Lewis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Connie Lewis wife 109 Talbot Ave., Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 3/9/09 Hurlock, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Hohe is I dorrow 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Aspiration **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any backing to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, the, as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 See 2 □ No 24a. Was an has le 2 autops perform 1☐ Yes this certificate 26. Place of Death (Check only of e) Be 25. Was case referred to medical examiner? 1 Yes 2 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 Director: After that in by the funeral 27. Mapper of Deth 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation Injury To the Hospital or Attending 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funeral C completely filled i

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

State Registrar

Medical

V. bric 31. Date filed (Month, Day, Year)

MAR 06 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Physician Letcher March 8, 10:30A M Carrie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Capital Heights 920 Kayak Ave If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 16, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year) Months Days Hours Min. 1 M 2 F 1924 Virginia Director 250 22 5529 84 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2√□ No Directo Capital Heights Maryland |Prince George's 10g. Citizen of What Country? 10e. Street and Number 20743 United States 920 Kayak Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2√√No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ Nyo Specify: Specify: White \$ 3 Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C& P Telephone Co. Telephone Operator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John G. Douffas Violet R. Mutispaugh ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12603 Cedarville Road, Brandywine, MD 20616 Johnna Latham (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) March 16, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Attending Physician: The law requires that the death certificate be executed COPD attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Tabacco Usage IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 T Residence 6 Other (Specify) 1∐ Yes 2∐**X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

32. Régistrar's Signature 31. Date filed (Month. Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Felton Anderson, MD 8507 Oxon Hill Road #102, Fort Washington, MD

D41182

March 10, 2009

| | | for State Registrar | State of Ma | ryiand / Depa <i>Ce</i> . | artment of F rtificate of | | | ne .no2009 | 09280 |
|--|-------------------|---|--|--|--|---|--|---|---|
| Physicia | nn. | 1. Decedent's Name (First, Middle, La | st) | _ | | | 2. Date of Death | Day Year | 3. Time of Death |
| /Medic | | | cClure | | | | March | 10,200 | 9 0114 |
| Examin | er | 4a. Facility Name (If not institution, give | | | | r Location of Death | | 4c. County of Deat | |
| Funeral | | Washington Coun 5. Social Security Number 6.5 | Sex 7. Age | (In yrs. last birthday) | If Under 1 Year | | 8. Date of Birth- | | ngton hplace (State or Foreign untry) |
| Director | | 217-28-7297 Usual Residence of Decedent | XX M 2□ F | 76 Yrs. | Months Days | Hours Min. | June 8, 1 | 1932 Penr | untry) nsylvania |
| yland Now | | 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| e Mar Sa-fsi | Director | Maryland Washi | ngton | | Hagerstov | vn | | | 1 □ Yes 2 No |
| iff the | Dire | 10e. Street and Number | | | 10f. Zip Code | | 10g. | . Citizen of What Co | untry? |
| s 23a | eral | 17618 Heisterbo | | main 11 C 10 | 1 | 21740 | agifu Va a er Ne | USA 14 Bass Ame | |
| 4 O E | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ev Armed Forces? **YEYes 2 □ No If Yes, Give Year or Dates: | , 1901- | was Decedent of F If Yes, specify Cub 1 □Yes 2 XNo | dispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | 14. Race - Ame Black, White Specify: Wh | |
| 72 hours "natural", idical Exe | ted | 15. Decedent's E (Specify only highest gra | ducation | 16a. Dece | dent's Usual Occup | oation | ing 16t | b. Kind of Business/ | |
| ithin 7 ne. han "r | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) |) | | during most of work d) | | | |
| Hygiel | | 17. Father's Name (First, Middle, Last |) | O | wner and | Operator | Pr e (First, Middle, Mai | | al Cleaning |
| d be f ental l ced or | Be c | | cClure | | | _ | | cherich | |
| should and Me mark | ٩ | 19a. Informant's Name/Relationship | | 19b. Mailii | ng Address (Street | | al Route Number, C | | Zip Code) |
| and 2 aalth a 27 is er tra | | Dwayne McClure - | Son | 1170 | 6 Pinesbu | ırg Rd. Wi | lliamspor | rt, Maryla | and 21795 |
| of He | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ | Removal from State | 20b. Place of Dispo cemetery, crei | sition (Name of natory or other pla | ce) | Date 200 | c. Location - City or | Town, State |
| Pag tment tant: I | | 4 □ Dopation 5 □ Other (Speci | (9) | | | | | Hagerstov | m, Maryland |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. | | 21. Signature of Funeral Service Lice | hsee // | | | merally Hon | • | liamenort | , MD 21795 |
| | | 23a. Far. 1. Enter the disease, or comshock, or heart failure. List only | plications that caused t | | | | | - | Approximate |
| Physician | 8 8 | Immediate Cause (Final | one cause of each line | | ardial | Illan | ction | | Interval Between Onset and Death |
| /Medical | | disease or condition resulting in death) | a. Due to (or as a | consequence of): | may | Jugare | CCCC | | , , , , , |
| Examiner | | Sequentially list conditions. | b | | | | | | |
| ted isit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a | consequence of): | | | | | |
| xecut al-tran | xan | that initiated events resulting in death) Last | c Due to (or as a | consequence of): | | | | | |
| tificate be executed g physician and as the burial-transit | | | d. | | | | | | |
| rtifica ng ph as th | Medical | IC CEMALE. | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | s decedent pregnant pe past 12 months? Yes 2 No 1 | | | | | | |
| s that | by P | Part II. Other significant conditions | contributing to death but | 1 11 1 | / | n 1 | 23e. Did tobac | co use contribute to | the cause of death? |
| equire een sig | ted t | SIMBLES / | ullus. | -ug/ | erluse | 070. | 1 ☐ Yes | 2 No 3 Pr | obably 4 Unknown |
| The law rate has be age 2 sh | Completed | Myperlep | delle | , ' | | | 24a. Was an autopsy performed | prior to death? | topsy findings available completion of cause of |
| ian:] rtiffica stor, p | Be C | 25. Was case referred to medical | | - Contraction of the Contraction | | 26. Place of Deatl | 1 ☐ Yes 2 ☐ h (Check only one) | TNO I LIYES | 2 No |
| hysic his ce I direc | | examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatien | t 2 ER/Outpatier | nt 3 DOA Oth | er: 4 🗆 Nursing Ho | me 5 Residence | e 6 □Other (Spec | cify) |
| ing P | .:io | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, | Year) 28b. Time o | Wor | k? | 28d. Describe how i | njury occurred | |
| ttend death stor: / | icati | 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not b | e 290 Place of Injur | y - At home, farm, str | | Yes 2□No | 28f. Location (Stree | t and Number or Pi | und Pouto Number |
| al or A after J Direc d in by | Certification: To | 4 ☐ Homicide determined | building, etc. | (Specify) | eet, factory, office | | City or Town, S | State) | rai noute Number, |
| To the Hospital or within 24 hours afte To the Funeral Direction of the | Medical (| 29a, Certifier 1 Certifying Pi (Check only one) 2 Medical Exam | nysician: To the best of miner: On the basis of and manner state | examination and/or in | h occurred at the ti vestigation, in my o | me, date and place, opinion, death occur | and due to the caus red at the time, date | se(s) and manner as and place, and due | stated. to the cause(s) |
| To th withir To th | Me | 29b. Signature and title of certifier | | | 29c. Licens | | 29d. | Date signed (Month | n, Day, Year) |
| | | > SAMUEL Chi | AN, MD. | | 0360 | 555 | Ma | net 10 | 2009 |
| jH-4+1 | | 30. Name and address of person who 324 East ANTIG | | ath (Item 23a) (Type, | Print) 200 - 1. | Hogeiten | W, MD | 11740 | |
| Stat Registra | | 31. Date filed (Month Ray Yar) 2 | 009 32. Pegistrar | 's Signature | and I | | , | | |
| nogistic | | | The state of the s | - Pe 18 | AN THE PARTY OF TH | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Bernard Ellwood Murphy, Sr. 7:05PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HICOMIC REGIONAL 544136414 TENINSUM MUSICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 23,1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Social Security Number Hours Months Days 1**X** M 2□ F Maryland 218-16-5848 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 □ No Vienna Maryland Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21869 USA 204 Middle Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fertilizer Co-Op Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Fleming Thomas Owen Murphy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Middle Street, Vienna, MD 21869 Phyllis M. Murphy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State St. Paul's Cemetery 3/11/2009 Vienna, Maryland 4 ☐ Donation, 5 ☐ Other (Specify) 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 21. Signature Funeral Service Lix ns Approximate Interval Between Onset and Death Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Toyar Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

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or items 23a

"natural"

al Hygiene. filed within

Mental pe

permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If Item 27 Is marked of any Injury or other traumatic ever once.

other traumatic event, the Medical Examinar quart be notified at

Funeral Director

Completed by

Be

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72 hours after death with the Maryland

Baltimore, Maryland 21215-0036 $^{\prime\prime}$

Examiner and burial-trar been signed by the attending physician should be detached for use as the burial Physician/Medical Completed by page 2 s certificate director Be Certification: To

The law requires that the death certificate be executed Hospital or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral din After this

P.O. Box 68760,

of Vital Records,

Division

State Registrar

Medical

31. Date filed (Month, Day,

29a. Certifier

29b. Signature and title of certifier

min

m

M.D. P.R.M.C egistrar's Signature 32

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

100E. Carroll St.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2 Date of Death 3. Time of Death Month Day Year **Physician** 315 A UMMIL 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🖫 F Yrs. 195-24-2641 76 Pennsylvania **Director** 12/01/1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Wedical Examiner must be notified at 1 XYes 2 No Director Bowie MD Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 12202 Fleming Lane Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's College (1-4or 5+) Elementary/Secondary (0-12) Food Service Manager County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be Donald Cousins Pauline Bailev ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Franklyn R. McGee/Spouse MD 20715 12202 Fleming Lane Bowie, permit. Pages 1 an Department of Hes Important: If item any Injury or othe once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 03/07/2009 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Beall Funeral Home NW Crain Hwy. Bowie, MD 20715 6512 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MILLEN 118100 disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Month Day Year 5 Other (specify) s been signed by the selection should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? certificate l After this certification funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check or 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier 29c. License number 012275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) and Sunk 300 America 900 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAR 09 2009

| imothy Francis | | 1- For State Registrar | e of Maryland | | rtment of tificate of | | | Menta | l Hyg | | g. No. 20 | 009 | 9 0928 |
|---|---------------|--|--|----------------------|---|--------------------|-----------------------------------|--------------------------|-------------------------------------|---|---|--------------------------|---|
| Physicia Medical Exami | | 1. Decedent's Name (First, Middle,L $$T$$] | MOTHY FRAN | ICIS M | | | | | | Date of Death Month March 5, 2 | Day Year 009 | | 3. Time of Death 1749 hrs |
| | | 4a. Facility Name (if not institution, g 3841 Eaves Lane | 4 | b. City, To Bowie | wn, or Lo | ocation of E | Death | | 4c. County of Death Prince George's | | | | |
| Funeral Director | | | Sex 7. Ag X M 2 F | | ast birthday) O Yrs. | If Under Months | 1 Year Days | | 4Hrs Min | | h(мм/DD/YYYY) 04/1959 | | place (State or Virginia ntry) |
| any | | Usual Residence of Decedent 10a. State 10b. County | <u> </u> | 10c. City, | Town or Location | on | | | | | | | 10d. Inside City Limits |
| ≥ | 5 | MD Prince | George's | | Во | wie | | | | | | - 1 | 1 X Yes 2 No |
| r 28a-f | Director | 10e. Street and Number | | | | 10f. Zip (| | | | 10 | g. Citizen of Wha | t Count | ry? |
| with the | | 3841 E. | aves Lane | t Ever in U. | S. 13. Was | Deceden | 20716 of Hispa | | ? (Spec | ify Yes or No- | | . S . A | an Indian, Black, |
| r death or iten must b | Funeral | 1 Never Married 2 Marri | 1 X Yes 2 | No | | | | Mexican, Po | uerto Ri | can, etc.) | White, | | |
| urs afte | ē | 3 Widowed 4 X Divorc 15. Decedent's Education (Specify | ed If Yes, Give Year 19 only highest grade con | 82-1989 npleted) | 16a. Decedent | | ccupation | n (Give kin | | | Specify: 16b. Kind of Busi | Whi iness/In | |
| 16 n 72 hoi an "na ical Ex | oletec | Elementary/Secondary (0-12) | College (1-4 or | | Ü | | working life. DO NOT use retired) | | | | | | |
| d within | Completed | 12 17. Father's Name (First, Middle, La | st) | | | Offic | | anage .Mother's N | | irst, Middle, M | A1 faiden Surname) | ıtom | otive |
| 1215 libe file gntal H arked o | Be | | nry F. Mil | ler | | | \perp | | | | y M. Fo | | |
| Baltimore, MD 21215-0036 permit, Pages I and 2 should-be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 75a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | 70 | 19a. Informant's Name/Relationship Patricia A. Jack | , | | 19b. Mailing | | | | | | ber, City or Town, | | |
| re, N s 1 and f Health ff item er trau | | 20a. Method of Disposition 1 X Burial 2 Cremation | | | Place of Disposit crematory or other | ion (Name | | | | Date | 20c. Location - 0 | | |
| timo trant: | 1 | 4 Donation 5 Other Spec | ify: | alc | umbia Gar | dens | | | 3/1 | 1/2009 | Arling | ton, | Virginia |
| Bal permi Depar Impo injur | | 21. Signature of Funeral Service Lic | ensee | | | ame and A | | | e, 13 | LO2 W.Br | oad St.,Fa | 11s ' | 22046 Church VA |
| Physician /Medical | | 23a. Part I. Enter the disease, or confailure. List only one cause on | nplications that caused each line. | the death. | | | | | | | | | Approximate Interval Between Onset and |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) | a. Carbon Monoxi | | | | | | | | | | Death |
| | | Sequentially list conditions, | b | | | | | | | | | | |
| | Examiner | if any, leading to immediate . cause. Enter Underlying Cause (Disease or injury that initiated | Due to (or as a cons | | | | | • | | | | | |
| ecuted and transit | | events resulting in death) Last | Due to (or as a cons | equence of | f): | _ | | | | | | | |
| O, e be exe ysician burial - | edical | UNPENDED | AMENDED | | | | | | | | | | |
| Box 6876(ne death certificate the attending phy- | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outco | | 2 Feta | al death | 3 | Ectopic pr | regnanc | у | 23d. Date of d Month | elivery Da | ay Year |
| Box e death c the atten ed for us | ysic | 1 Yes 2 No 9 Unknow | 4 Pregnant a yn g Unknown | time of de | ath 5 Oth | er (Specii | ý) | | | | | | |
| P.O. Is that the gned by the detache | by Pr | Part II. Other significant condition | s contributing to deat | h but not re | esulting in the ur | nderlying o | ause give | en in Part I | | | | _ | ne cause of death? |
| ords, P.C. w requires that s been signed should be dete | | | | | | | | | - 8 | 24a. Was a | | | opsy findings available |
| Records, The law require ficate has been si | Completed | | | * | | | | | _ | autops perform | | ior to co ath? Yes | mpletion of cause of |
| tal Rec cian: The certificate ector, page | Be | 25. Was case referred to medical examiner? | | | | 26 | | f Death (Ch | neck on | | | | |
| of Vitaling Physician After this certioneral director | 2 | 1 ✓ Yes 2 No 27. Manner of Death | 128a Date of Init | ent 2 | ER/Outpatient 28b. Time of In | | | ther: 4 N at Work? | | | Residence 6 | | Scene |
| ion c tending eath. for: Af | gig | 1 Natural 5 Pending 2 Accident Investige | FOUND: Day, | (ear) | FOUND: 1720 hrs | · · I | | s 2 🗸 No | lini | | | | carbon monoxide |
| Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Functal Director: After this certificate has been signed by the attending physician and let filled in by the funeral director, page 2 should be detached for use as the burial - transition of the contract of the | ertification: | 3 ✓ Suicide 6 Could not determine 4 Homicide | 28e. Place of Ir | | ome, farm, street | , factory, o | office buil | lding, etc. | 38 | Bf. Location (S or Town, St 41 Eaves La | itreet and Number ate) ane, Bowie, MD | or Rura | al Route Number, City |
| the the | / N L | 20a Cortifier | ician: To the best of mer:On the basis of exa | y knowledg | ge, death occurr | | | | , and du | e to the cause | e(s) and manner a | s stated | |
| | ₩ We | 29b. Signature and title of certifier | and manner stated. | | | | License r | | | | 29d. Date signed | | h, Day, Year) |
| 10 B) | | Yameh 9 mithae | (, mo | 11- /!- | 00-) | | O.C.M. | .E. | | | March 6, 20 | <u> </u> | |
| 2) | | 30. Name and address of person wh Pamela E. Southall, MD | | | | Penn S | Street, | Baltimor | re, MC | 21201 | | | |
| St Regist | | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signatu | re | | | - | | | | | |
| | _ | ***** | | 7 | | | | | | | - | | |

For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** 3:15 p^M Μ. Matthews 2009 Mar /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner PRINCE GEORGE'S 1762 ALBERT DRIVE MITCHELLVILLE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month. Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F 74 Director 241-66-3386 SEPT. 19 1934 FLORTDA Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat harst be rediffied at once. 1 TYes 2 □ No Director MD PRINCE GEORGE'S MITCHELLVILLE 10e. Street and Number 10g. Citizen of What Country? 1762 ALBERT DRIVE Funeral 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 □ No ARMY If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 Tho Specify: BLACK 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NURSE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSBORNE MARTIN ည ANNIE LEE MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1762 ALBERT DRIVE MITCHELLVILLE, MARYLAND STEVEN MARTIN/SON 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL CEME 4/1/2009 ARLINGTON, VIRGINIA 21. Signature of Funeral Service 22. Name and Address of Facility J. D. JENKINS FUNERAL HOME -7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC CERVICAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ØNo Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ∰Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 5, 2009 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN WELTZ M.D. GREENWAY CENTER DRIVE GREENBELT, MARYLAND 31. Date filed (Month, Day, Year) **MAR 1 1** 2009 32. Registrar's Şignature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

items 23a or 28a-f show iner must be notified at

| Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL EXEC. CLARK | 200 | 72 hours af "natural", or | d by | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 □Yes | | | |
|--|--|---|----------|--|---|------------------------|---|--------------------------|---|---|
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | L | "nati | lete | 15. Decedent's Ed (Specify only highest gra | de completed) | 16a. | Decedent's Us (Give kind of wallife DO NOT | sual Occ vork don | upation ne during most of work red) | king |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | 5 | withii giene. | mo | Elementary/Secondary (0-12) | College (1-4or 5+) 2 YRS | | | | | |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | 2000 | ild be filed fental Hyg rked othe tic event, | Be | | | | | | | |
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| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | 2 | and 2 ealth n 27 l | | RICHARD MCCLAIN | | | | | | RIVERDA |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A condition of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | Pages 1 nent of H ant: If iter | | 1 XBurial 2 ☐ Cremation 3 ☐ | nemovariioni state | Place of cemeters | Disposition (N v, crematory or LNCOLN | ame of other p CEM | lace) ETERY 3/16 | |
| Physician [Medical Examiner] Sequentially list conditions, if any, leading to immediate before the medical ending from the medical example of the medical examp | 100 | permit. Departr Imports any inju | | 21. Signature of Funeral Service Lica | nsee | | | | , | |
| isease or condition resulting in death) Americal Examiner Sequentially list conditions, if any, leading to immediate it any, leadi | | | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only | plications that caused the de- | ath. Do n | ot enter the m | ode of d | ying, such as cardiad | or respiratory ar |
| Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Intracranial Bleed Due to (or as a consequence of): Dye to (or as a consequence of): Dye to (or as a consequence of): | | | | disease or condition | . Fatal | Car | diac. | Ar | rythn | 110 |
| Sequentially list conditions, if any, leading to immediate b. Dye to (or as a consequence of): | | | | resulting in death) | Due to (or as a conse | equence o | f): | R | 122-1 | |
| Space Spac | | Lamanci | 7. | Sequentially list conditions, | b. Printo (or as a conse | Ul | <u>ual</u> | P | icea. | |
| That inlined events that inlined ed events resulting in death) Last Comparison of the content | | nsit | ij | cause. Enter Underlying Cause (Disease or injury | HUDECH | 605 | INAL | | | |
| Comparison of the control of the c | , | exection end is all tra | | | | | | | | |
| FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 24a. Was autop performed and one of the standard | 0750 | ate be shysicial the bur | dical | • | d | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to 1 1 1 1 1 1 1 1 1 1 | So the second of the past 12 months? IF FEMALE: 23c. If yes, outcome of pregnancy 1 | | | | | | | | | |
| Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the determined 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. Li | 2 | that that the ned by | y Ph | Part II. Other significant conditions | contributing to death but not re | esulting in | the underlying | cause (| given in Part I. | 23e. Did to |
| 24a. Was a autop performed by the part of | 7 | quires quires en sign uld be | | | | | | | | 1 □ Y |
| 25. Was case referred to medical examiner? 1 | 200 | The law rete has bee | omplete | | | | | | | 24a. Was a autop perfor |
| Comparison of Participation of Partici | | ian: ortifice stor, p | Se C | 25. Was case referred to medical | | | | | 26. Place of Dea | |
| 27. Manner of Death 1 | 7 | nysice | | | Hospital: 1XInpatient 2 | ☐ ER/Out | patient 3 🗆 [| DOA C | Other: 4 \sum Nursing H | lome 5 Resid |
| 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Ho | 9 | nding Pt ath. r: After the | ation: | 1 Natural 5 ☐ Pending | (Month, Day, Year) | | jury | | | 28d. Describe h |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier and manner stated. 29c. License number | | al or Atte s after de il Directo | Sertific | - determined | 28e. Place of Injury - At building, etc. (Spec | home, far cify) | m, street, facto | ory, office | е | 28f. Location (S City or Tow |
| 29c. License number 29c. License number | | ne Hospit n 24 hour ne Funera | | (Check only 2 Medical Example 1 | miner: On the basis of exami | nowledge nation and | , death occurre d/or investigation | ed at the | time, date and place y opinion, death occu | e, and due to the urred at the time, |
| 4 1 CA 1/30318 | | To th within To th | Me | 29b. Signature and title of certifier | 1 | | 2 | 9c. Lice | nse number | |
| | | 4 | | 1/ 1/24 | | ٠ | | | 30318 | 3 |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 6^{ay}2009 MARCH 6:00 P THOMASINA R. MCCLAIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV . 23 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 19<u>47</u> Months Days Hours Min. NORTH CAROLINA 1 ☐ M 2 🖳 F Yrs. 241-80-8577 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No Director MD PRINCE GEORGE'S RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20737 USA 6613 POWHATAN STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: BLACK 16b. Kind of Business/Industry GOVERNMENT Maiden Surname) ER er, City or Town, State, Zip Code) LE, MARYLAND 20737 20c. Location - City or Town, State BRENTWOOD, MARYLAND ENKINS FUNERAL HOME ER, MARYLAND 20785 rest. Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day bacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No rmed? 2 No 7e) lence 6 Other (Specify) ow injury occurred treet and Number or Rural Route Number, n, State) cause(s) and manner as stated. date and place, and due to the cause(s) nth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEMETRIOS CATEVENIS M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar DHMH 17 Rev 1/2001

| | | | State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death | | ene 1. N2 0 0 9 | 09286 | |
|---|---|-----------------------|--|---|--|---|--|
| | Physic /Medi Examir | cal | 1. Decedent's Name (First, Middle, Last) Benjamin Raymond McRoberts 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | 2. Date of Death Month | Day Year | 3. Time of Death | |
| | Funeral Director | | 5. Social Security Number 6. Sex 1 XM 2 F 68 7. Age (In yrs. last birthday) Months Days Hours Min. 1 XM 2 F 1 XM 2 F 68 Yrs. | 8. Date of Birth Month, Day, Y July 31, | 9. Birti 1940 Mar | hplace (State or Foreign unity) 'Yland | |
| . | the Maryland 28a-f show notified at | ector | 10a. State 10b. County 10c. City, Town or Location MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code | 100 | a. Citizen of What Co | 10d. Inside City Limits 1 Yes 2 No | |
| 0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral Director | 100 Revolution St. Apt. 202 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 1 □ Yes, Give Year or Date \$\frac{1}{2} \overline{9} \overline{1} \overline{9} \overline{9} \overline{1} \overline{9} \overline{1} \overline{9} \overline{1} \overline{9} \overline{9} \overline{1} \overline{9} \overline{9} \overline{1} \overline{9} \o | | U.S.A. 14. Race - Amer Black, White | rican Indian, e, etc. | |
| 21215-0036 | ed within 72 h rgiene. er than "natu ; the Medical | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Laborer | king 16 | Production | | |
| Maryland | hould be file d Mental Hy marked othe matic event | To Be (| 17. Father's Name (First, Middle, Last) 18. Mother's Name John McRoberts 19b. Mailing Address (Street and Number or Rui | · | | | |
| Baltimore, Ma | Pages 1 and 2 sh nent of Health and int: if item 27 Is m iry or other traum | - 3 | Charlotte C. Long (Friend) 641 Old Robin Hood Rd. 20a. Method of Disposition 1 Removal from State 4 Donation 5 Other (Specify) Charlotte C. Long (Friend) 641 Old Robin Hood Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Mem. Gdns. 3/20 | Aberde Date 20 0/09 Be | een, Maryl Oc. Location - City or el Air, Ma | and 21001 Town, State | |
| 760, Physician / Medical Examiner and penual-transit e burial-transit | Physician /Medical Examiner e prival-transit | Aedical Examiner | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring—Cargo Fune Aberdeen, Maryland 23a. art1. Enter the disease, or complicitions that caus the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | 21001-3 | 3399 | Approximate Interval Between Onset and Death | |
| .O. Box | the death celly the attendir | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify) | | 23d. Date of deli Month | ivery Day Year | |
| Records, P. | v requires that the been signed by the should be detache | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow | | |
| or Vital Re | Physiclan: The law r this certificate has be ral director, page 2 sh | Be Completed | examiner? | autopsy performe | prior to death? ZNo 1 □ Yes | topsy findings available completion of cause of | |
| Division or | Attending r death. ector: After by the funer | Certification: To | 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 See. Place of injury - At home, farm, street, factory, office 4 Nursing Household - Nursi | tome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical C | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29c. License number | rred at the time, dat | use(s) and manner as the and place, and due to Date signed (Month | to the cause(s) | |
| _ | | ate | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOUGH A. (1) ONO W. H. WIKHMI) / HILLIHOFF (31. Date filed (Month, Day, Weyr) O. A. O. Sa Registratis Signature | KUM, Per | 27 km7, v | 116/21902 | |

Registrar

| Physic | ian | 1- For Amend Item Registrar 1. Decedent's Name (First, Middle, L Ellen Irene I | ast) | | | · · · · · · · · · · · · · · · · · · · | 0 01 1 | Journ | | 2. Date of I Month | Death | Day | () 9 Year | 0 9 2 8 |
|--|----------------|---|--|-----------------|-------------------------------|---------------------------------------|--------------------------------|---------------------------|-----------------------------|---|--------------------|--|-------------------------|--|
| /Med Exami | | Ellen Irene I 4a. Facility Name (If not institution, gi | Pritchett | er) | | 4h City | Town or | Location | of Death | March | 8, | 2009 4c. County | | 3:50 P |
| LAGIIII | IICI | Calvert Memoria | Hospita. | 1 | | | | rede | | | | Calv | | |
| Funeral Director | | 577-20-5716 | Sex 7. 1 □ M 2 1 F | Age (In yrs. 92 | last birthday Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of E 1/1/18 | Birth Day, Ye | 16 | 9. Birth | place (State or Fore ntry) Sinia |
| at at | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | y, Town or L | ocation | | | | | | | | 10d. Inside City Lim |
| lified | ctor | MD Calvert | ; | So | lomons | 5 | | | | | | | | 1 □Yes 2 ∑ I |
| a or 28 be no | Director | 10e. Street and Number 11100 Asbury Circ | Jo A-+ 1 | 100 | | 10f. Zip | | | | | 1 | Citizen of | What Cou | ntry? |
| ms 23 | Funeral | 11. Marital Status | 12. Was Decede | | S. 13. | | 688 ent of Hi | spanic Ori | gin? (Sne | cify Vee or N | 1 | JSA | a - Amorio | can Indian, |
| n or nearth and wental hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Force 1 ☐ Yes 27 If Yes, Give Year or Date: | s? No | | If Yes, spec | | n, Mexicar Specify: | i, Puerto I | cify Yes or N Rican, etc.) | 40- | | ck, White, | etc. |
| "natur edical I | Completed | 15. Decedent's E (Specify only highest gr | ducation ade completed) | | (Give | dent's Usua kind of wor | k done d | lurina maci | t of workir | na | 16b | . Kind of B | | |
| than the Me | dwo | Elementary/Secondary (0-12) | College (1-4d | or 5+) | lite. | DO NOT usi maker | e retired, |) | | <i>'</i> 9 | T. | Iome | | |
| d other | Be C | 17. Father's Name (First, Middle, Las | ") | | 110111 | | | | | (First, Middl | e, Maio | | ne) | |
| narked | P | Aubrey Jacobs | | | | | | | | nthon | , | | | |
| 27 Is m | | 19a. Informant's Name/Relationship (Rebecca Petricoi | | langhta | 19b. Maili 76 | 25 Gr | eat | Dover | or St. | Gain | ber Cit | $11^{T_{\mathbf{e}_{m{j}}}^{T_{\mathbf{e}_{m{k}}^{wn,}}}}$ | VA Z | 6135 |
| item r othe | | 20a. Method of Disposition | | 20b. PI | lace of Dispo | osition (Nam | e of | a) ; | Da | ate | 20c. | Location - | City or To | wn, State |
| tant: If | | 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci | JRemoval from Sta | | bury C | emete: | ry | ່ 3 | 3/11/ | 2009 | Pr | ince | Fred | erick, M |
| Important: If item 27 Is any Injury or other tra | | 21. Signature of Juperal of Rice (see | John H MO146 | | nes 2 | 2. Name and 3125 Sc | Address | s of Facility em M | Lee Iarv1 | Funera | il H | lome (| Calve | rt P.A. MD 20736 |
| bhysician and ledical aminer the prival-transit | dical Examiner | disease or conditions a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | 2 days |
| attending for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | 2 Fetal | death 3 | Ectopic pre | | | | | | 23d. Date of delivery Month Day Year | | |
| been signed by the should be detached is | by | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | 23e. Did tobacco use contribute to the ca | | | | A . |
| certificate has bee irector, page 2 sho | Completed | | | | | | | | | | psy ormed2 | , d | rior to con eath? | sy findings availat apletion of cause o |
| is certifica director, I | Be C | 25. Was case referred to medical examiner? | | | | | , ; | 26. Place | of Death (| 1□ Yes Check only | 2 X one) | 10 1 | □Yes | 2□ No |
| .v. 0 | - To | 1 ☐ Yes 2 【No 27. Manner of Death | Hospital: 1 Nopal | | R/Outpatien | | | 4 ☐ Nurs | | e 5 Resi | | | |) |
| r: Afte | ation | Natural 5 Pending 2 Accident investigation | (Month, D | ay Year) | Injury | м 200 | c. Injury a Work? 1 □ Ye | at es 2.∐N | | id. Describe | now inj | ury occurre | ed | |
| by t | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Local Country - At home, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street, farm, str | | | | | | | f. Location (City or To | Street a wn, Sta | and Numbe te) | r or Rural | Route Number, | |
| in pi | Medical | 29a. Certifier Check on 2 Medical Exan | ysician: To the bes niner: On the basis and manner s | or examination | ledge, death on and/or inv | occurred at restigation, in | the time | , date and nion, death | place, an | nd due to the d at the time, | cause(| s) and mar nd place, a | ner as sta nd due to | ited. the cause(s) |
| ne Funeral Dir | 4 | 29b. Signature and Mig-of Certified | | | | 29c. L | _icense r | number | | | 29d. D | ate signed | (Month D | lav Voorl |
| To the Funeral Director: After th completely filled in by the funeral | Me | 29b. Signature and interolled inter | | | | - | | | | | | | | ay, rear |
| To the Funeral Dir completely filled in | Me | 30. Name and address of person who do | 7 | | | - |)46 | 419 | | | | 1091 | | ay, rear/ |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Day 06 ARY **Physician** 063U M 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12-11-1926 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🗷 F Months Yrs. Director 066-22-7114 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Tracy's Landing 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 20779 USA 6239 Solomons Island Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No δ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 11 department manager appliance store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Richard Balogh unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once. Richard C. Pirozzi, son 6239 Solomons Is. Rd., Tracy's Landing, MD 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/6/2009 | Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee William Cro 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liny Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or es a consequen of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation ♦ ☐ Yes 2 ☐ No 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

dew 3

State Registrar Name and address of per-

ICHAEL

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

ANNAPULI MD 1409

who mpleted cause of death (Item 23a) (Type, Print)

Registrar Signature

Wh

E

32.

| | | | 1 - For State of Maryland / Dep Registrar Ce | eartment of Health and Nertificate of Death | | ene a. No.2 () () () | 09289 |
|------------|--|----------------|--|---|---|---|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Death | | 3. Time of Death |
| | /Medic | al | Lorraine Mae PHILLIPS 4a. Facility Name (If not institution, give street and number) | 41. Cit. T | March | 8 200 | |
| , | Examir | er | Washington County Hospital | 4b. City, Town, or Location of Death | | 4c. County of Dear | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday | Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, | Washing (Year) 9. Bird | tholace (State or Foreign |
| | Director | | Usual Residence of Decedent | Working Days Flours Willi. | | | aryland |
| | ryland how | | 10a. State 10b. County 10c. City, Town or L. | ocation | | | 10d. Inside City Limits |
| | Ba-fs | Director | Maryland Washington Hagers | stown | | | 1 X Yes 2 □ No |
| | with the | | 10e. Street and Number | 10f. Zip Code | 100 | g. Citizen of What Co | untry? |
| | death ms 23 | Funeral | 1021 Rose Hill Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. | 21740 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- | USA 14. Race - Ame | |
| 36 | or ite | | 1 Never Married 2 Married 1 Yes 2 No | If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify: | Rican, etc.) | Black, White | e, etc. |
| 21215-0036 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the "Midral Ever the Trust be notified a | ed by | 3 Mad Widowed 4 □ Divorced Year or Dates: | | | | hite |
| 215 | hin 72 e. an "na | Completed | (Specify only highest grade completed) (Give | edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) | ing | 6b. Kind of Business/ | Industry |
| | filed witl Hygiene ther tha | Com | 11 0 Se | ecretary | | Floris | t |
| Maryland | s a a | Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Name | e (First, Middle, Ma | iden Surname) | |
| Ž | should and Mer is marke aumatic | ဥ | Norman Haupt 19a. Informant's Name/Relationship (Type. Print) 19b. Maili | Eva Bowe | | City or Town State 3 | Fin Code |
| | es 1 and 2 should b of Health and Ment fitem 27 is markec r other traumatic e | | | 21 Rose Hill AVenue | | | |
| Baltimore, | Pages 1 and the sent of He sent of He sent of He sent of the sent | | | | | c. Location - City or | |
| ti E | permit. Pages Department of Important: If it any injury or o | | 4 □ Donation 5 □ Other (Specify) Rose Hil | 1 Cemetery 3/12/ | '09 на | agerstown, | Maryland |
| Ba | perm Depa Impo any i | | | 2. Name and Address of Facility Mit | nnich Fun | eral Home | |
| | | | i 23a, Part I, Enter the disease, or complications that caused the death. Do not en | ter the mode of dying, such as cardiac | Hagerst or respiratory arrest | own, Md. | 21740 Approximate |
| | Physician | 1 | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | | , , , | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | (well |
| | | <u>-</u> | Sequentially list conditions, if any, leading to immediate b. Oue to (or as a consequence of): | 4THMIAS | | | Walks |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | even(49. |
| Ď, | e exec ian an irial-tri | Exa | resulting in death) Last C. Due to (or as a consequence of): | | | | 77((20) |
| 8760, | ficate be executed physician and s the burial-transit | dical | d | | | | |
| S S | e law requires that the death certifi has been signed by the attending ie 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | | | | * |
| . BOX | death le atte | icia | in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 1 ☐ Yes 2 ☐ No. 4 ☐ Pregnant at time of death 5 ☐ | ☐ Ectopic pregnancy ☐ Other (specify) | | 23d. Date of deli | very Day Year |
| 7. O | at the 1 by th stache | hys | 9 Unknown ' 9 Unknown | | | | |
| ďS, | | | Part II. Other significant conditions contributing to death but not resulting in the un | nderlying cause given in Part I. | | co use contribute to | |
| ecoras, | v requ | etec | | | - | 2 No 3 Pro | obably 4 Dunknown |
| Ĭ, | he lav te has age 2 | Completed by | | | 24a. Was an autopsy performed | prior to co | opsy findings available ompletion of cause of |
| VII | ian: T | ŭ∖ Be | 25. Was case referred to medical | 26. Place of Death | 1 □ Yes 2 🖟 | | 2 No |
| > 5 | hysic this ce al direc | ၉ | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatier | nt 3 DOA Other: 4 Nursing Hon | | e 6 ☐ Other (Spec | ify) |
| Sion | ding F | ö | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time of Injury (Injury) | Work? | 28d. Describe how i | njury occurred | |
| 2 | Attender of death of the of th | fical | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm, str | M 1 ☐ Yes 2 ☐ No | P8f Location /Stree | t and Number or Rur | n Pouto Akumbar |
| 5 | s after s all Dire | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify) | ,, | City or Town, S | itate) | ar noute lyumper, |
| | | edical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatl 2 Medical Examiner: On the basis of examination and/or in and manner stated. | h occurred at the time, date and place, a vestigation, in my opinion, death occurre | and due to the caus ed at the time, date | se(s) and manner as and place, and due | stated. to the cause(s) |
| | Vithir Comp | | 29b. Signature and title of certifier | 29c. License number | 29d. | Date signed (Month, | Day, Year) |
| | | | Y Ceay/MD | D46561 | | MARCH, | 08, 2009 |
| ک | H-1 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, GHMMA OH) IN 190 MT AETNA | Print) ROMO LAMBERGA | | 10 21: | 740 |
| | Stat Registra | ~ | 31. Date filed (Month, Day, Year) MAR 1 0 2009 32. Registrar's Signature | | | | 1 |
| | | | TITLE A V COUT LEMENTS OF A | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Physician 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner 5315 ted LIYING If Under 24 Hrs. 6. Sex Age (In yrs. last birthday If Unde 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F 8072 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State Town or Location or 28a-f show must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA "natural", or items 23a doa by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 No filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use tetired). than College (1-4or 5+) Elementary/Secondary (0-12) + marked other 17. Father's Name (First, Middle, Last, 3. Mother's Name (First, Middle, Maiden Surname, i 1 and 2 should be fill Health and Mental H tem 27 is marked otf Be ပ Informant's Name/Belationship 19b. Mailing Address (Street and Number or Rural Re City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of . Method of Disposition Date Pages 1 cemetery, crematory or other place) ↑☑ Burial 2 ☐ Cremation 3 ☐Removal from State ecilton, 4 Donation 5 ☐ Other (Specify) Name and Address of Facility ral Service Licenses DE 19805 23a. Part1. Enter the disease, or complications that caused the death of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any hading the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 ☐ Yes 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performe After this certificate 1∐ Yes 2 NO funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA Mano Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 255151VB 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural 1 TYes 2 □ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one and manner stated. 29b. Signature, and the of certifier 29d. Date signed (Month, Day, Year) 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

MAR 11 2009

32. Registrar's Signatur

amend line 11 per fd aaco hlth dept 3/9/09 dlw
01776 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01776 2009 09291 State of Maryland / Department of Health and Mental Hygiene Frances Orville Proctor Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 1611 hrs March 2, 2009 **Medical Examiner** Francis Orville Proctor 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Country) Maryland Director 213-34-5619 1 X M 2 76 Yrs 1032 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County any 10a State Yes 2 X No Davidsonville Maryland Anne Arundel 23a or 28a-f show notified at once. Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 3121 Beards Point Rd. USA 21035 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral White, etc. must be Armed Forces? 2 X Married 2 X No Yes Yes 2 X No specify: Specify: Black If Yes, Give Year Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene Widowed the Medical Examiner ð Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) JE Owens Completed College (1-4 or 5+) Elementary/Secondary (0-12) Equipment Operator Construction Co. 21215-0036 7th 0 18. Mother's Name (First, Middle, Maiden Surname) is warked other 17. Father's Name (First, Middle, Last event, Marv E Newman Be Joseph H. Proctor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21035 19a. Informant's Name/Relationship (Type, Print) P M M Emma M. Proctor(Wife) 3121 Beards Point Rd. Davidsonville, Md it: If item 27 i 20c. Location - City or Town, State Date 20bTPlace of Disposition (Name of cemetery, crematory or other blace) 20a. Method of Disposition Baltimore, Cremation 3 1 X Burial 2 Removal from State Memorial Gardens 3-9-09 Davidsonville, Md permit. Page Department (Important: injury or otl Donation 5 Other Specify 2Wmmpe and everse F&litySons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 D. Resar MOD 483 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death **Viedical** a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): n and - transit Physician/Medical AMENDED physician the burial -UNPENDED 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death use as t past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 V Unknown à diabetes mellitus Completed 24a. Was an 24b. Were autopsy findings available peen prior to completion of cause of autopsy death? performed? has 1 🗸 Yes 2 No ✓ Yes 2 page 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital director Be Other₄ Hospital: Residence 6 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: 1 V Natural Yes 2 No Pending the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) Could not be Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 3, 2009 O.C.M.E. completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

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| | | | For State Registrar | State of Ma | Ce, | rtificate of | | | Reg. No. | | 09292 |
|--------------------------------|---|----------------|---|---|--|---|---|---------------------------------|----------------------------------|--|--|
| | Physici | | 1. Decedent's Name (First, Middle, La Nellie Prado | st) | | | | 2. Date of De Month 03 - | Day | 2009 Year | 3. Time of Death 6:45a M |
| - Salan | /Medic Examin | | 4a. Facility Name (If not institution, giv Warm Heart Assis | | Inc | 4b. City, Town, o | or Location of Death | 1 | | County of Death | |
| | Funeral Director | | Social Security Number 6. S | 0 | e (In yrs. last birthday) | | If Under 24 Hrs. | 8. Date of Bir (Month, Da 2–18– | th ı <i>y</i> , Yea <i>r)</i> | 9. Birth | place (State or Foreigntry) to Rico |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or Lo | cation | | | | 1 | 10d. Inside City Limits |
| | Mary a-f sh | ctor | MD Prince | Georges | College | Park | | | | | 1X Yes 2 ☐ No |
| | vith the | Director | 10e. Street and Number | _ | | 10f. Zip Code | | | • | zen of What Cou | - |
| | eath w | Funeral | 4813 Nantucket R | oad 12. Was Decedent B | Everin U.S. 13 | 2074 | | necify Yes or No | | ted Stat | |
| 980 | ours after d al", or item Examinat | | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Forces? 1 ∐Yes 2 2 1 N If Yes, Give Year or Dates: | lo i | | Hispanic Origin? (S pan, Mexican, Puert Specify: Pue: | | | Black, White, Specify: His | etc. |
| Baltimore, Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be mailtied at | Completed by | 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) | ducation de completed) College (1-4or 5 | (Give | | during most of wor ed) | king | | nd of Business/In | dustry |
| d 2 | filed w Hygie other t | | 12 17. Father's Name (First, Middle, Last, | | | Homemak | 18. Mother's Nan | ne (First, Middle, | | Private Surname) | |
| /lan | uld be Mental irked c | To Be | Dimas Blanas | | | | Petra Ro | odiguez | | | |
| , Mary | 1 and 2 should be fi Health and Mental H em 27 Is marked of other traumatic eve | | 19a. Informant's Name/Relationship (Marlow A Prado Bl | Type Print) ankershin/ granddaugl | 19207 | | tand Number or Ru Dale Ct Bo | | | | Code) |
| more | Pages 1 and of He | | 20a. Method of Disposition 1★ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif | | 20b. Place of Disponder Crownsvill Cemet | lle Veter | ns 3-9- | Date -2009 | | cation - City or Townsvill ϵ | |
| Balti | permit. Pages 'Department of P Important: If ite any Injury or of | | 21. Signature of Funeral Service Licer | shing to | 22 | 2. Name and Addre | ess of Facility For | t Linco | 1n F | uneral H | lome |
| | Physician /Medical | | 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | one cause on each lir | the death. Do not ente. Dementia a consequence of): | ter the mode of dy | ing, such as cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death years |
| | Examiner | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | bDue to (or as | a consequence of): | | | | | | |
| 68760, | tificate be executed g physician and as the burial-transit | edical Exar | that initiated events resulting in death) Last | C. Due to (or as | a consequence of): | | | | | | |
| O. Box | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it | Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal death 3 | ☐ Ectopic pregnan ☐ Other <i>(specify)</i> _ | су | | 2 | 23d. Date of deliv Month | ery Day Year |
| ds, P. | uires that n signed b id be deta | þ | Part II. Other significant conditions of | ontributing to death bu | ut not resulting in the u | nderlying cause gi | ven in Part I. | | | | he cause of death? |
| of Vital Records, | : The law requir cate has been si page 2 should I | Completed | | | | | | | | 24b. Were auto prior to co death? 1 □ Yes | opsy findings available impletion of cause of |
| /ita | | Be C | 25. Was case referred to medical examiner? | | | | 26. Place of Dea | | | I La Tes | 2 🗆 100 |
| of V | Phys this al dii | ဥ | 1 ☐ Yes 2 ☑ No 27. Manner of Death | | nt 2 ER/Outpatier | IL 3 LI DUA | | | | Other (Speci | fy) |
| Division | ding 7. After fune | Certification: | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b | | y, Year) Injury | M 1 C | rk?]Yes 2∐No | 28d. Describe I | | | - I Daniel Alemania |
| Div | urs afte rral Dir | | 4 ☐ Homicide determined 29a. Certifier 1⊠ CertifyIng Pl | building, etc | of my knowledge, deat | | time, date and place | City or Tox | wn, State) | | al Route Number, |
| | H 22 H at | Medical | (Check only 2 Medical Examone) | niner: On the basis of and manner sta | f examination and/or in | vestigation, in my | opinion, death occu | urred at the time, | date and | place, and due t | o the cause(s) |
| AN | To the within To the comple | M | 29b. Signature and title of certifier | 1) oh | | 29c. Licen | se number | 8 | | e signed (Month, 3-6-2009 | |
| | 3 | | 30. Name and address of person who | | | | | | | 5-0-2005 | <u>' </u> |
| | | | Steven Dolinsky S | | L Ave Gaith | nersburg | MD 20879 | 9 | | | |
| | Sta | te | on Date in a way, Ital) | Z JZ. Hegistra | and degrication of | | | | | | |

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 Inez Payton March 4. 14:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Medical Center Fort Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 578-26-7793 1 ☐ M 2 【XF Director April 19, 1917 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Marylan ntal Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Prince George's Accokeek Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18301 Indian Head Highway 20607 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 2 3 ☐ Widowed 4 ♣ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Charwoman Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Cannon Jeanette James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adolphus Payton - Son 7103 Shield Court Upper Marlboro, MD 20772 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Mar 13, 2009 Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licens 4001 Benning Road, NE Washington, DC 20019 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician erose /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | → Nown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 2 1 ☐ Yes 1 🔲 Inpatient 2 R/Outpatient 3□ DOA this 27. Manner of De th 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After completely filled in by the funeral (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 To the Hospital o within 24 hours aft To the Funeral Di

8

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

ZHARZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

05472

29d. Date signed (Month, Day, Year)

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| | | | For 1 _ State | State of | Maryland | | artment of rtificate o | | | lental Hy | | / 11 11 | 9 1 | 9294 |
|-------------------|---|----------------|--|---|------------------------------|-----------------------------|--------------------------------------|------------------------|--------------|------------------------------|------------|---------------------------|-------------------------------|-------------------------------|
| | | | Registrar 1. Decedent's Name (First, Middle, | Last) | | | inoaic c | Death | | 2. Date of De | Reg. N | 0 0 | | ne of Death |
| г | Physici | _ | | t Read | | | | | | Month March | D | ay Year 2009 | | |
| (%) (165 | /Medic Examir | | 4a. Facility Name (If not institution, | | er) | | 4b. City, Towr | n, or Location | of Death | Harch | | c. County of De | | .5 1 |
| 1 | EXAMIN | iei | Solomons Nursin | - | , | | So1omo | | | | | Calver | t | |
| 17 | Funeral | | | 6. Sex 7. | Age (In yrs. la | ast birthday) | If Under 1 Ye | | | 8. Date of Bir | rth | 9. B | irthplace (St | ate or Foreign |
| ы | Director | | 155-09-9985 | 1 🟋 M 2 🗆 F | 92 | Yrs. | Months Day | ys Hours | Min. | (Month, Da March | 17 | 1916 N | ew Jer | sey |
| Side | p | | Usual Residence of Decedent | | 140.00 | _ | | | | | | | | |
| | arylar show d at | _ | 10a. State 10b. County | | | , Town or Lo | cation | | | | | | | de City Limits Yes 2 |
| | 8a-f | Director | Maryland Calvert | | Solom | nons | | | | Т | | | | |
| | with the | ä | 10e. Street and Number | | | | 10f. Zip Cod | le | | | | Citizen of What C | • | |
| | s 23 | eral | 13442 Lore Pines Lar | 12, Was Decede | ont Ever in II S | 12 1 | 20688 | of Hienanic O | rigin? (Sne | cifu Vas or No | | ted State | | n |
| | item item | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie | Armed Force | es? | | Was Decedent of If Yes, specify C | | | Rican, etc.) | J - | Black, Wh | rite, etc. | |
| 336 | urs af | by | 3 MWidowed 4 ☐ Divorced | If Yes, Give Year or Date | | | 1□Yes 2ŪX1 | No Specify | <i>:</i> | | | Specify: Wh | ite | |
| 21215-0036 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notitled at | ted | 15. Decedent's | s Education | | 16a. Dece | dent's Usual Oc | cupation | -4 -61.2 | | 16b. | Kind of Busines | s/Industry | |
| 218 | hin 7 9. An "n Medi | Completed | (Specify only highest Elementary/Secondary (0-12) | College (1-4 | or 5+) | | kind of work do DO NOT use rei | ne during mo tired) | St of Worki | ng | | | | |
| 21 | filed withir Hygiene. other than ent, the Me | Son | | 4 | | Sales | man | | | | _ | xd & Bever | age | |
| Maryland | 0 = 0 % | Be (| 17. Father's Name (First, Middle, L | ast) | | | | 18. Moth | er's Name | (First, Middle | , Maide | en Surname) | | |
| yla | 2 should be f h and Mental I Is marked of raumatic eve | 2 | James Paulding R | | | | | | ia De | | | | | |
| lar | 2 sh and Is m | | 19a. Informant's Name/Relationshi | | | | | | | | | or Town, State | Zip Code) | |
| 2 | and lealth m 27 her t | | Nancy McCabe / I |)aughter | Took Die | | Box 55 | | | ate MD 20 | | | - T 01-1 | |
| Baltimore, | ges 1 If of F If Ite or ot | | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation | | ate | | sition (Name of matory or other | 1 | | | | Location - City of | | |
| ij | t. Pa rtmer rtant: | | 4 □ Donation 5 □ Other (Sp | ** | Metr | | n Cremato 2. Name and Ad | | 03/09/ | | | exandria, | | a |
| Bal | permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic enonce. | | 21. Signature of Funeral Service L | Ma 1 | .(1 | 22 | . Name and Ad | idress of Facil | | | | Home, P.A | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | usby, rub | Approx | rimate | |
| ш | 197 | | shock, or heart failure. List o | nly one cause on eac | h line. | la ca | L C:1. | ayg, cao, a | o our aido c | or respiratory o | .,, | | Interva | l Between and Death |
| Ŕ | Physician /Medical | | disease or condition resulting in death) | a CM | onc. | Mear | T tacil | ue- | | | | | ļ | |
| | Examiner | | | A h | as a consequ | 6 bail | abin | , | | | | | | |
| ы | 28 No | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or | as a consequ | ence of): | WITTO | | | | | | | |
| | uted ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | AN | Name | il a | ac | | | | | | | |
| ó | execunan an an inal-tr | Еха | resulting in death) Last | Due to (or | as a consequ | ence of): (| Í | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit | dical | , | d | | | | | | | | | | |
| 9 | rtifica ng ph as th | led | IE EENALE. | I | | | | | | | | | | |
| Box | leath certific attending p | an/l | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outco 1 ☐ Live birt | me pf pregnar th 2 Fetal | |]Ectopic pregna | ancy | | | İ | 23d. Date of d | | Van |
| | e dea the at ned fo | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnar 9□Unknow | nt at time of de | eath 5□ | Other (specify |) | | | | Month | Day | Year |
| P.0 | res that the de signed by the a be detached t | Phy | Part II. Other significant condition | ne contributing to dea | th but not recul | Iting in the u | ndorlying cause | given in Part | | 23a Did | tobacco | use contribute | to the cause | of death? |
| ds, | ires ti signe | by | Tarrii. Other alginireant condition | is contributing to deat | in but not resul | iling in the u | nderlying cause | giveninian | 1. | | | 2 No 3 □ 1 | | 4 Zenknown |
| or Vital Records, | w require been si should t | Completed | | | | | | | | | | | | |
| 3ec | e law has b | ldm | | | | | | | | 24a. Was | | 24b. Were prior to death? | autopsy findi o completion | ings available of cause of |
| al | | | | | | | | | | 1□ Yes | 2 1 | | s 2 No | |
| Ζij | Physiclan: The la this certificate har ral director, page 2 | Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: | | -D/Otti | , 0U DOA | a | | (Check only | | | =3.2. | |
| | <u> </u> | : To | 27. Manner of Death | 28a. Date of | Iniury | ER/Outpatier 28b. Time o | | njury at Work? | | me 5 ☐ Hesi 28d. Describe | | 6 ☐Other (Sp | pecify) | |
| on | nding Ph th. : After this funeral | tion | 1 Natural 5 Pending 2 Accident investiga | | Day Year) | Injury | | Worƙ? 1 ∐ Yes 2 ⊑ |]No | | | , | | |
| Division | l or Attending after death. Director: After in by the fune | fica | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin | 20e. Flace of | f injury - At hor | me, farm, str | eet, factory, offi | ice | | | | and Number or i | Rural Route | Number, |
| ă | al or s afte | Certification: | 4 Horrilloide | bullaring | , etc. (Specify, | , | | | | City or To | wn, Sta | iie) | | |
| | To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the | | | Physician: To the be xaminer: On the bas | | | | | | | | | | lea/e) |
| | the H in 24 the Fi | Medical | one) | and manne | | | | | aiii occuri | ed at the time | , uate a | ind place, and d | ue to the cat | 158(5) |
| | To the within 2 To the comple | Σ | 29b. Signature and title of certifier | | | | 29c. Lic | ense number | j | | 29d. D | ate signed (Mo | nth, Day, Ye | ar) |
| | | | 1 (48) | (IN | | | D5 | 8577 | | | Marc | ch 9, 2009 | 9 | |
| 10 | 11/12 | | 30. Name and address of person w | | | | | | | | | 100 -01- | | |
| an | WIU | | Gwyneth A. Bla 31. Date filed (Month, Day, Year) | | 14090 So gistrapis Signat | | Island R | load, Sui | te 250 | JU, Solar | nons, | , MD 20688 | 3 | |
| | Sta Regist | | | -9 2009► | | | Buck | 1 | | | | | | |
| | | | ******* | 0 -000 | MACHER | - 141 | Sales and the new | | | | | | | |

| | | | For State Registrar | State of Ma | ryland / Dep <i>Ce</i> | artment of H ertificate of I | | lental Hy | giene Reg. No.2 | 009 | 09295 |
|--|----------------|----------------|--|--|--------------------------------------|--|--------------------------------|--|-----------------------------|------------------------|---|
| Phy | | | Decedent's Name (First, Middle, La. | st) Beraldine M | urphy Rei | d | | 2. Date of De Month March | Day | Year 2009 | 3. Time of Death |
| | edic: ımine | | 4a. Facility Name (If not institution, give | | arpiny ivoi | | Location of Death | Waren | | ounty of Deat | |
| T. | | Н | 1055 Stagecoach Trail | | | Lusby | I If II also Callin | | Calve | | |
| Fune Direc | 1 | | 5. Social Security Number 6. S 259-56-3914 Usual Residence of Decedent | ex 7. Age | (In yrs. last birthday | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bi (Month, Da July 9, 1 | ay, Year) | 9. Birt Co Alaba | thplace (State or Foreign ountry) ama |
| yland | 6 | ŀ | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | | 10d. Inside City Limits |
| e Man la-fsh | | ctor | MD Calvert | | Lusby | | | | | | 1 ☐Yes 2X No |
| vith th | 2 | Director | 10e. Street and Number | | | 10f. Zip Code | | | | n of What Co | ountry? |
| eath v | isnii i | Funeral | 1055 Stagecoach Trail | 12. Was Decedent B | ver in U.S. 13. | | 20657 ispanic Origin? (Sp | ecify Yes or No | USA 0- 14 | . Race - Ame | erican Indian. |
| offer d | | | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☑ N | | Was Decedent of H | | Rican, etc.) | | Black, White | |
| ILE 15-UUSO filed within 72 hours after death with the Maryland Hygiene. Wither than "natural", or Items 23a or 28a-f show ant the Medical Evaminar mist he notified at | EYG | d b | 3 ₩ Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 ☒ No | Specify: | | | - | Black |
| n 72 h | 200 | Completed | 15. Decedent's Ed (Specify only highest gra | ide completed) | (Give | edent's Usual Occup e kind of work done o DO NOT use retired | during most of work | ing | 16b. Kind | of Business/ | Industry |
| L L Withi | | mo | Elementary/Secondary (0-12) | College (1-4or 5- | +) | al Worker | , | | s | Social Sei | rvices |
| d be filed antal Hyg | , delle | Be C | 17. Father's Name (First, Middle, Last, |) | , , , , , , , , , , , , | | 18. Mother's Name | e (First, Middle | , Maiden Su | ırname) | |
| should be and Mental marked o | | <u>-</u> | | an Murphy | | | | | cila Bee | | |
| d2sh d2sh thand thand 7 Is m | | | 19a. Informant's Name/Relationship (| | | ling Address <i>(Street i</i> 5 Stagecoach | | | | own, State, 2 | Zip Code) |
| If \$\int\$, INIAI YIAIIQ \(\textit{LI3-UU30}\) s.1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27: Is marked other than "natural", or Items 23a or 28a-f show other trainmatic event it he Madical Examiner must be notified at | | | Maxine Reid - Daughte 20a. Method of Disposition | | 20b. Place of Disc | | 1 | Date | | ation - City or | Town, State |
| mit. Pages partment of portant: If II by | 5 | | 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif | | 1 | ands Mem. Ga | i | 009 | Port Re | epublic. | MD |
| permit. Pages 1 an Department of Heal Important: If Item 2 and in the permit is a permit of the permit is a permit of the permit is a permit in the permit is a permit in the permit is a permit in the permit in th | once. | | 21. Signature of Funeral Service Licer | nsee | 2 | 22. Name and Addres | ss of Facility | | | | ederick, MD 20678 |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused | the death. Do not er | | | | | rillice i le | Approximate Interval Between |
| Physici | ian | | Immediate Cause (Final disease or condition | | putic monsum | all cest Juna | (ancel | | | | Onset and Death |
| /Medio | - | | resulting in death) | Due to (or as a | consequence of): | , | | | | | |
| Bert | 100 | e. | Sequentially list conditions, | b. Due to (or as a | consequence of | | | | | | |
| cuted | 1010 | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | C | | | | | | | |
| oe exe | n al | Ë | resulting in death) Last | Due to (or as a | a consequence of): | | | | | | |
| icate be ex physician | | edical | | _d | | | | | | | |
| h certif | מפת | Me. | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | Mc | | | 230 | d. Date of del | livery |
| ed for | 20 00 | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 □Live birth 4 □ Pregnant at 9 □ Unknown | | ☐Ectopic pregnancy ☐ Other (specify) | | | | Month | Day Year |
| hat the deby the | ממכו | | 9 ☐ Unknown Part II. Other significant conditions of | | it not resulting in the | underlying cause give | en in Part I | 23e Did | tohacco use | contribute to | the cause of death? |
| The law requires that the death certificate be executed ate has been signed by the attending physician and hand 2 should be detached for use as the hirriat-transit | an na | od by | - | | | | | | | | obably 4 Unknown |
| 1 a a | J I | Completed | | | | | | 24a. Was | | 24b. Were au | utopsy findings available |
| The cate h | Page | Sol | | | | | | perf 1∐ Yes | ormed? 2 No | death? 1 ☐ Yes | • |
| VILC siclan certifi | | Be | 25. Was case referred to medical examiner? | Hospital: | | ont 3D DOA Oth | 26. Place of Deatler: | | | | |
| Physe or this | 5 | ٦. | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 28a. Date of Injur | y 28b. Time | of 28c. Injur | 4 LI Nursing Ho | me 5 Res 28d. Describe | | | cify) |
| tending eath. | | atio | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | | Year) Injury | | k? Yes 2 □ No | | | | |
| To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director page. | n fol III | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | | ry - At home, farm, s . (Specify) | treet, factory, office | | 28f. Location (City or To | (Street and I wn, State) | Number or Ru | ural Route Number, |
| ospita hours uneral | ily illied | | 29a. Certifier 1 Certifying Pt | nysician: To the best on miner: On the basis of | of my knowledge, dea | ath occurred at the tir | ne, date and place, | and due to the | cause(s) ar | nd manner as | s stated. |
| the H thin 24 the F | libia l | Medical | one) | and manner sta | ted. | 29c, Licens | | | | signed (Monti | |
| 5 iž 6 g | 3 | | 29b. Signature and title of certifier | | | | SLOZY | | | vih S | |
| (Au) / | | | 30. Name and address of person who | completed cause of de | eath (Item 23a) (Type | e, Print) | na Tvole 1 | HI | | | |
| KW 6 | Stat | | Kemeth L. Assott 31. Date filed (Month, Day, Year) | | | | | (I) | 46 10 | | |
| Reç | Sta gistra | | MAR - | 9 2009 A | eners & | parker | , | | | | |

09-02069 Dale Eugene Roberts Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 09296

| | | 1- For State Certificat | te of I | Death | | F | Reg. No. | | , ,,, |
|--|----------------|--|-------------------------|--|--------------|------------------------|---------------------|-----------------|---|
| Physici cal Exami | an/ | Decedent's Name (First, Middle,Last) | | 2 | 7. | 2. Date of De Month | | | 3. Time of Death |
| al =xaliii | ner | Dale Eugene Roberts 4a. Facility Name (if not institution, give street and number) | 177 | Cit. T | - 1,1-0, | March 13 | 3, 2009 | | 1248 hrs |
| | | 41 Frederick Street | | Cumberland | | 1 * *0 * | 4c. County of | | |
| Funeral | 11 | Social Security Number | | | | 8 Date of B | , | | place (State or Fore |
| Director | | | | | ours Min. | To. Build of B | arar(IVIIV/DD/TTTT | Count | |
| | A Prince | 216-54-7916 | Yrs. | | | Feb. | 7,1950 | L _{Ma} | ryland |
| any | | 10a. State 10b. County 10c. City, Town or | Location | n | | | | 1 | 0d. Inside City Limi |
| nd show ce. | <u>-</u> 1 | Maryland Allegany | | Garage and | - | | | | 1XXYes 2 N |
| aryka 8a-f | cto | 10e. Street and Number | | Cumberla 10f. Zip Code | ina_ | 17 | 10g. Citizen of Wh | | |
| rith the Maryland 23a or 28a-f show a notified at once. | Director | 41 Frederick St. Apt. 2 | | 215 | 0.0 | 5 6 | | | , , |
| with 132 232 e not | | | 13. Was | 2150 Decedent of Hispanic C | | ecify Yes or N | 0- 11/ Page | USA | n Indian, Black, |
| after death with the Marykand al", or items 23a or 28a-f sho ner must be notified at once. | Funeral | 1 X Never Married 2 Married Armed Forces? | If Yes | s, specify Cuban, Mexic | can, Puerto | Rican, etc.) | White | | indian, black, |
| ifter o | | 3 Widowed 4 Divorced If Yes, Give Year | 1 Y | es 2 X No spec | cify: | | Specify: | T.7 ? | hite |
| | d by | 15. Decedent's Education (Specify only highest grade completed) 16a. Dec | ecedent's | Usual Occupation (Given | ve kind of w | ork done | 16b. Kind of Bus | | |
| 72 h | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) | ring mos | t of working life, DO NO | OT use retir | ed) | | 10. | |
| within 72 iene. er than " Medical | m d | 11 | S | elf Emplo | bayo | | Furniture | o Dofi | nichon |
| Hyg oth the | | 17. Father's Name (First, Middle, Last) | | 18. M oth | her's Name | (First, Middle, | Maiden Surname) | = VEIT | mser |
| Mental Mental marked c event, | Be | Alden Jeremiah Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. N | | Ka | thor | ino To | uico V | - wn - | |
| and M | 70 | | Mailing A | Ka Address (Street and N | Number or R | ural Route Nu | mber, City or Town | ı, State, Z | ip Code) |
| 7 = 7 = 1 | | Anna Holland - Sister 61 | 1 0 | bservator on (Name of cemetery, | ry Dr | . Haq | erstown | ı. MI | 21742 |
| of He | | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of C crematory | Disposition y or other | on (Name of cemetery, r place) | | Date | 20c. Location - | City or To | wn, State |
| permit, rages I and Department of Healt Important: If item injury or other tra- | | 4 Donation 5 Own Specific Smiths | bur | g Cremato | orv 3 | -16-0 | 9 Smith | chin | ca Mary |
| porting inch | 1 | 2.7 Egilate 6 of File Control Control Control | 22 Nar | me and Address of Faci | Home | D 7 | 7 DILL CII | SDUI | . q, mar y |
| FUE | | 23a. Part I. Enjer the disease, or complications that caused the death. Do not e | 425 | S. Chrombe | eaue, s | r.A. h Willi | amenort M | D 215 | 705 |
| ysician | | 23a. Part I. Enfer the disease, or complications that caused the death. Do not e failure. List only one cause on each line. | enter the | mode of dying, such as | s cardiac or | respiratory an | rest, shock, or hea | | Approximate Interv |
| ledical aminer | | Immediate Cause (Final disease a. Primary (Hypertens | sive |) Right Rag | cal C | nolia | Uomorrho | | Between Onset an Death |
| | | or condition resulting in death) Due to (or as a consequence of): | JIVC. | / Kight has | Sal Ge | mgira | пешоггла | ge | |
| | _ | Sequentially list conditions, b | | | | | | | |
| | aminer | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | 1 | | | | | |
| .= | ä | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | \rightarrow | |
| and | Ä | d | | | | | | | |
| ician irial | <u>ë</u> | X UNPENDED AMENDED 23a,27 per | me g | g890 4-20-0 | 09 vt | | | | |
| incate be executed ng physician and is the burial - transit | | IF FEMALE: 23c. If yes, outcome of pregnancy | | | | | 23d. Date of d | delivery | |
| as as | ä | . Progrant of time of death | Fetal | death 3 Ecto | pic pregnar | су | Month | Day | Year |
| e atter | Sic | Yes 2 No 9 Unknown 9 Unknown 9 Unknown | Other | (Specify) | | | | | |
| 14 hours after death. 14 hours after death. Funeral Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use a | Physicia | Part II. Other significant conditions contributing to death but not resulting in | n the und | erlying cause given in | Part I | 23e Did to | obacco use contrib | uto to the | onung of domina |
| signed by | <u></u> | g | | ionymy cadoc given in | T GILT. | | | | ly 4 V Unknown |
| een si | ted | | | | | 24a, Was | | | |
| has b | Completed | | | | | autop | osy pri | ior to com | sy findings available pletion of cause of |
| certificate rector, page | 튅 | | | | | 1 Yes | | eath? ✓ Yes | 2 No |
| certif ector, | Be | 25. Was case referred to medical examiner? | | 26.Place of Deat | th (Check o | nly one) | | | |
| r this | 잂 | 1 Yes 2 No Prospital 1 Inpatient 2 ER/Outpa | | | Nursing | Home 5 | Residence 6 | Other: Sc | ene |
| After | اڃَ | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time | ne of Injur | | | 28d. Describe | how injury occurred | d | |
| tor: / the | ; 달 | Natural 5 Pending 2 Accident Investigation | | 1Yes 2 | No | | | | |
| after death Director: I in by the | <u></u> | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, | , street, f | factory, office building, | etc. 2 | 8f. Location (| Street and Number | or Rural i | Route Number, City |
| within 24 hours after death. To the Funeral Director: completely filled in by the | Certification: | 4 Homicide determined (Specify) | | | | or Town, S | otate) | | |
| e Firr | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of | occurred | at the time, date and p | place, and d | ue to the caus | se(s) and manner a | s stated. | |
| within 24 hours To the Funeral completely filled | ᄝᆫ | one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. | stigation | , in my opinion, death o | occurred at | the time, date | and place, and due | e to the ca | iuse(s) |
| | Σ : | 29b. Signature and title of certifier | | 29c. License numbe | er | | 29d. Date signed | (Month, | Day, Year) |
| | | Mall | | O.C.M.E. | | | March 14, 20 | 009 | |
| | | 30. Name and address of person who completed cause of death (Item 23a) | | <u> </u> | | | | | |
| 0 | | Ana Rubio MD. Assistant Medical Examiner 111 Per | nn Stre | eet, Baltimore, MI | D 21201 | | | | |
| Sta | | 31. Date filed (Month, Day, Year) 32. Redistrar's Signature | _ | | | | | | |
| Registr | ar | MAR 17 2009 | has | and the same of th | | | | | |
| 7 Rev 1/200 | 01 | ORIGI | INAL | - | | | OCME | | |
| or alth | | ÇI (II) | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day 3/3/2009 JOSEPH DONNELL RICHMOND 9:21 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON HOSPITAL PRINCE GEORGE'S FORT WASHINGTON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Days 1 ★M 2 F 244-80-8342 58 1/30/1951 Mebane, NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Oxon Hill 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5915 Shoshone Drive 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Independence Specialist Independence Now 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Richmond Lucille Thaxton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda Richmond / Wife 5915 Shoshone Drive Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial 3/11/2009 Suitland, Maryland 22 Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licens 01085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence 1002 P consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year

Physician /Medical Examiner

physician and s the burial-tran

signed by the at d be detached fo

cate has t-een sig

þ

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

or Attending Physician:

To the Hospital

After

the

filled in by

24 hours after death.

within 24 hor To the Fune completely fi

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

r 28a-f shov notified at

item 27 is marked other than "naturai", or items 23a or other traumatic event, the Medical Examiner must be in

and Mental Hygie is marked other

item 27 i

permit. Pages 1
Department of H
Important: If ite
any Injury or ot

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

Examine Physician/Medical IF FEMALE:

4☐ Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performe 1∏ Yes

25. Was case referred to medical examiner? 1 Tyes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

26. Place of Death (Check only one)

27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

11711 Livingston Road Fort Washington, Maryland 20744-5164 Samuel Kleiman 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

MAR 11 2009

| | | | for State Registrar | State of N | /laryland / [| Department of Certificate o | | Mental Hy | /giene Reg. No. 200 | 9 09298 |
|-------------------|---|----------------|---|---|--|--|---|----------------------------------|--------------------------------------|--|
| | | | Decedent's Name (First, Mid | ddle, Last) | | | | 2. Date of De | eath | 3. Time of Death |
| | Physici /Medio | | Willie | Robert Rob | inson | | | March | 6, 2009 Yes | 2:42 ам |
| | Examin | | 4a. Facility Name (If not institution | | r) | | , or Location of Deat | h | 4c. County of D | |
| and the | | | Holy Cross H | | Name (In two look his | | r Spring | 8. Date of Bi | Montgo | Omery Birthplace <i>(State or Foreigr</i> |
| | Funeral Director | | 5. Social Security Number 224-34-2923 | 1 M 2 F | Age (In yrs. last bir | Yrs. Months Day | | April | 16, 1918 Bu | Country) ichanan, Va. |
| | and sw t | | Usual Residence of Decedent 10a. State 10b. Count | nty | 10c. City, Town | n or Location | | | | 10d. Inside City Limits |
| | Mary I-f she | tor | D.C. | | Washi | ington | | | | 1≹Yes 2□No |
| | h the | Director | 10e. Street and Number | | | 10f. Zip Cod | 9 | | 10g. Citizen of What | Country? |
| | th wit | ral | 725 Somerset | P1. N.W. | | 2001 | | | United : | States |
| 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Ma 3 🔀 Widowed 4 ☐ Divorce | If Yes, Give | s?]No | 13. Was Decedent of If Yes, specify C | of Hispanic Origin? (Suban, Mexican, Puerl Book Specify: | Specify Yes or Note Rican, etc.) | | merican Indian, hite, etc. Black |
| 5-0 | 72 hc | Completed | 15. Decede (Specify only high | ent's Education hest grade completed) | 16a. | Decedent's Usual Oc (Give kind of work do life, DO NOT use ret | cupation ne during most of wo | rking | 16b. Kind of Busine | ss/Industry |
| 121 | within ene. than ' | ldm | Elementary/Secondary (0-12) 9th |) College (1-4o | | ome Constru | | | Private 3 | Industry |
| d 2 | filed y | | 17. Father's Name (First, Middle | le, Last) | 110 | ome donsere | | ne (First, Middle | e, Maiden Surname) | |
| lan | lld be fental rked c | To Be | Lenwood Robin | nson | | | Anna L | ucy Bur | ks | |
| , Maryland | and 2 should be filed within 7: palth and Mental Hygiene. n 27 is marked other than "n er traumatic event, I'v. Med | | 19a. Informant's Name/Relation | | | . Mailing Address <i>(Stre</i> 270 4th Str | | | ber, City or Town, State • 24066 | e, Zip Code) |
| Baltimore, | | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other | | | f Disposition (Name of ry, crematory or other popolitan | olace) 3/1 | Date 0/2009 | 20c. Location - City Alexandr | |
| Ball | permit. Pa Departmer Important: any injury once. | | 21. Signature of Funeral Service | ce Licenson | 401085 | 22. Name and Ad Alexand 5538 Ma | | e P.A. | stville, Mo | d. 20747 |
| | | | 23a. Part 1. Enter the disease shock, or heart failure. Li | or complications that caus ist only one cause on each | ed the death. Do line. | not enter the mode of | dying, such as cardia | c or respiratory | arrest, | Approximate Interval Between |
| 1 | Physician | | Immediate Cause (Final disease or condition | a_ Conge | stive Hea | art Failure | <u> </u> | | | Onset and Death Months |
| | /Medical Examiner | | resulting in death) | | as a consequence | • | | | | 77 |
| Ь | | er | Sequentially list conditions, | D | miac Caro | liomyopathy of: | ' | | | Years |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | | , | | | | |
| ó | ficate be executed physician and s the burial-transit | Еха | resulting in death) Last | Due to (or a | as a consequence | of): | | | | |
| 68760, | ate be nysicia he bu | edical | | d | | | | | | |
| 99) | ertifica ling ph e as th | Med | IF FEMALE: | | | | | | | |
| .O. Box | or Attending Physician: The law requires that the death certificate be executed ther death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit. | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 2 ☐ Fetal death t at time of death | 3 ☐ Ectopic pregna 5 ☐ Other (specify | | | 23d. Date of Month | delivery Day Year |
| σ. | res that signed b be deta | by Pr | Part II. Other significant condi | itions contributing to death | but not resulting in | the underlying cause | given in Part I. | 23e. Did | tobacco use contribute | to the cause of death? |
| rds | quire; en sig uld be | | Diabetes Me | 11itus | | | | 1 🗆 | Yes 2 No 3 | Probably 4 🔀 Unknown |
| of Vital Records, | : The law requir cate has been s page 2 should | Completed | Chronic Rena | al Insuffiend | су | | | 24a. Was auto perf | ormed? death | autopsy findings available to completion of cause of ? |
| ta | ian: The rtificate tor, pag | | 25. Was case referred to medic | cal | | | 26. Place of Dea | | | es 2 No |
| > | ysician: is certific director, | To Be | examiner? 1 ∐ Yes 2 🙀 No | Hoenital: | ntient 2 ☐ ER/Ou | utpatient 3 DOA | D#I | | sidence 6 Other (S | pecify) |
| o uo | iding Phy th. After thi funeral o | tion: T | 27. Manner of Death 1 ↑ Natural 5 Pend | 28a. Date of Ir (Month, L | | | njury at /ork? □Yes 2 □No | T | how injury occurred | ,, |
| Division | after death, Director: A | Certification: | 3 ☐ Suicide 6 ☐ Coul | rmined 200. Place UII | njury - At home, fa etc. <i>(Specify)</i> | rm, street, factory, office | e | 28f. Location City or To | (Street and Number or own, State) | Rural Route Number, |
| | Hospita 24 hours Funeral tely fille | Medical C | | ying Physician: To the beat Examiner: On the basis and manner | of examination ar | | | | | |
| | To the within 2 To the comple | Me | 29b. Signature and title of certif | fier | | | ense number | | 29d. Date signed (Mo | |
| | 6 | | / mm | Lew 12 | | D3 | 2332 | | March 6, | Z009 |
| | | | 30. Name and address of persons SK Gupta, N | | | (Type, Print) 7e. #220 Si | lver Spri | ng, Md. | 20902 | |
| | Sta | | 31. Date filed (Month, Day, Yea | ar) 32 Regis | strar's Signature | had. | | | | |
| | Registr | ui | MAR 11 | LUUJ KROW | w p. p. | gave | | | | |

| 09-01063 | Please Type or Print in Bla | ack Indelible Ink. Ensure All Copie | es Are Legible. | | |
|-------------------|--|-------------------------------------|------------------|---------|-------------|
| Norma Sue Reymond | | Department of Health and Mental H | | 2000 | 00200 |
| | For State | Certificate of Death | Reg. No. | 2009 | 09299 |
| Physician/ | . Decedent's Name (First, Middle,Last) | | 2. Date of Death | | ne of Death |
| Medical Examiner | Norma Sue Reymond | | February 5, 2009 | Year 08 | 312 hrs |
| | a Facility Name (if not institution, give street and number) | 4h City Taylor and norther of Donat | 4- 0- | | |

| Dhi.i. | Registrar 1. Decedent's Name (First, Middle,Last) | | Reg. No. |
|--|--|--|--|
| Physician/ Medical Examine | Norma Sue Reymond | | Date of Death Wonth Day Year ebruary 5, 2009 3 Time of Death 0812 hrs |
| | Facility Name (if not institution, give street and number) 22463 Sara Court | 4b. City, Town, or Location of Death California | 4c. County of Death St. Mary's |
| Funeral Director | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 215-17-0995 1 M 2XF 38 Y | Months Days Hours Min. | Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland |
| w any | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local | | 10d. Inside City Limits |
| th the Maryland 23a or 28a-f show notified at once. | Maryland St. Mary's Great Mil 10e. Street and Number | 1 S 10f. Zip Code | 1 Yes 2 X No |
| ith the hand the notified | | 20634 | USA |
| hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once ed by Funeral Director | | /as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Rica | white, etc. |
| ours aft atural' kamine | or Dates: | Yes 2X No specify: ent's Usual Occupation (Give kind of work | done 16b. Kind of Business/Industry |
| 2 3 1 7 | Elementary/Secondary (0-12) College (1-4 or 5+) 11 Shif | most of working life. DO NOT use retired) t Manager | Rite Aid |
| 21215-0036 Juld be filed within 7 I Mental Hygiene. marked other than ic event, the Medica | | 18.Mother's Name (Fir | st, Middle, Maiden Surname) |
| | | Mary Ire | ne Davis Route Number, City or Town, State, Zip Code) |
| MD and 2 should hand in 27 is aumatic | · | | lechanicsville, MD 20659 |
| ا څاو ه ه | 1 Burial 2 X Cremation 3 Removal from State crematory or c | ther place) Feb. 1 | 20c. Location - City or Town, State |
| Baltimore, permit. Pages 1 an Department of Hee Important: If ite injury or other tr | 21. Signature of Funeral Service Licensee 22. | ld-Echols Crem. Name and Address of Facility rinsfield-Echols Fu | Charlotte Hall, MD |
| Physician | Garyton Echols, III, (per DVR) 30 | J195 Three Notch Rd | Charlotte Hall. MD 20622 |
| /Medical xaminer | failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methadone, oxycodone and alcohologo or condition resulting in death) Due to (or as a consequence of): | ol intoxication | Between Onset and Death |
| iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | | |
| uted d ansit Examiner | (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | |
| be exectician arrival - tr | UNPENDED X AMENDED #21 per FD G88 | 39 3/24/09 TT | |
| res that the death certificate be executed signed by the attending physician and the detached for use as the burial - transit d by Physician/Medical Exd | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | etal death 3 Ectopic pregnancy other (Specify) | 23d. Date of delivery Month Day Year |
| P.O. B es that the d gigned by the detached be detached by the detached by the by Phy | 1 | underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown |
| cords law requi | | | 24a. Was an autopsy performed? ✓ Yes 2 No 1 ✓ Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N |
| of Vital Recing Physician: The After this certificate funeral director, page on: To Be Com | 25. Was case referred to medical | 26.Place of Death (Check only | |
| F Vit | 1 V Yes 2 No Hospital 1 Inpatient 2 ER/Outpatier | | |
| ttending leath. | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Peb 5, 2009 28b. Time of FOUND: FOUND: Found: F | | . Describe how injury occurred nown |
| Division o spiral or Attending nours after death. meral Director: After filled in by the fune Certification: | 3 Suicide 6 Could not be determined (Specify) Single Family | | Location (Street and Number or Rural Route Number, City or Town, State) 63 Sara Court, California, MD |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. | | |
| A N | 29b. Signature and title of certifier | 29c. License number O. C. M.E. | 29d. Date signed (Month, Day, Year) February 6, 2009 |
| | 30. Name and address of person who completed cause of death (Item 23a) | 1 Penn Street, Baltimore, MD 2 | 1201 |
| State Registrar | | | |
| | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type of Printin Black-Indelible 17/26 Fire use All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 3, Charles Henry Shadwell, Jr. 2009 17:33 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 704 War Bonnet Trail Lusby Calvert 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) June 22, 1928 West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 212-24-2480 80 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f show a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Maryland Calvert Lusby 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a 20657 United States "natural", or items 23a 704 War Bonnet Trail by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 1 No 1f Yes, Give 1946-1948 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 XWidowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than is 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other than Accounting Department of Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Henry Shadwell Mary Delphia Bean 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Alan Shadwell / Son 9613 51st Place, College Park, MD 20740 permit. Pages 1 a
Department of Hes
Important: If Item
any Injury or othe 20a. Method of Disposition
1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mar. 5, 2009 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Sign the of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that guised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final antein Physician Coronany years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the enjury Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 💸 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy performed? 1☐ Yes 2☐ No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 025156 Garles Bennett M.D. March 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lew) 11845 H.G. Trueman Road, Lusby, MD 20657

Registrar

State

Charles W. Bennett, MD 31. Date filed (Month, Day, Year)

32. Registra s Signature 2009 MAR Darke 13

| | | 1 | For State Registrar | State of M | Maryland | | artmen rtificate | | | and Mo | | iene eg. No. | 009 | 09301 |
|------------|--|----------------|--|--|---------------------------|-------------------------|--|---------------------|-----------------------------|-------------------------|---|----------------------|-------------------------------|---|
| | | | 1. Decedent's Name (First, Middle, Las | it) | | | | | | | 2. Date of Deat Month | h Day | Year | 3. Time of Death |
| | Physicia /Medic | | Katherine Lorra | aine Spu | rrier | | | | | | March | 12 | 2009 | |
| | Examin | 45 | 4e. Facility Name (If not institution, give | | er) | | 1 | | Location o | | | 4c. C | ounty of Dea | |
| | | | 1226 Grand Lega | | | | | | rstow | | - D . (D:4) | | Washi | |
| | Funeral | | 5. Social Security Number 6. S | ex 7. □M 2 X F | Age (In yrs. last | birthday) Yrs. | Months | 1 Year Days | If Under 2 Hours | Min. | 8. Date of Birth (Month, Day, OCt. 1.6, | Year) | 9. Bin | thplace (State or Foreign buntry) ryland |
| | Director | - | 214-22-6928 Usual Residence of Decedent | | 80 | 113. | | | | | 001.107 | 1920 | l'id | Lytand |
| | and | - H | 10a. State 10b. County | | 10c. City, T | own or Lo | cation | | | | | | | 10d. Inside City Limits |
| | Mary 1 sho | ō | Maryland Washi | naton | | Н | agers | town | | | | | | 1 □ Yes 2X No |
| | the 28a | 9 | 10e. Street and Number | .9.0 | | | 10f. Zip | | | | 1 | 0g. Citize | en of What Co | ountry? |
| | 3a or | | 1226 Grand Lega | ry Drive | | | | 2 | 1740 | | | | USA | |
| | death ms 2 | Funeral | 11. Marital Status | 12. Was Decede | nt Ever in U.S. | 13. | Was Deced | | | gin? (Spe | cify Yes or No- Rican, etc.) | 14 | 4. Race - Ame Black, Whi | |
| စ | after or Ita | E. | 1 ☐ Never Married 2 ☐ Married | 1 Yes 2 | Ö₩o | I | 1 □ Yes | | Specify: | | , | 9 | Energify: | |
| ဗ္ဗ | ours ral', | d b | 3 Widowed 4 □ Divorced | Year or Date | | | | | | | | | | White |
| 21215-0036 | within 72 hours after death with the Maryland ene. than 'natural', or Itams 23a or 28a-f ahow the Maryland Examiner must be notified at | Completed by | 15. Decedent's Ed (Specify only highest gra | ducation de completed) | 1 | (Give | dent's Usua kind of wo DO NOT us | rk done o | during most | t of workir | ng | 16b. Kind | d of Business | vindustry |
| 12 | han han | mp | Elementary/Secondary (0-12) | College (1-4 | or 5+) | | ecret | | , | | | | Non P | rofit |
| 7 | lied v lygie ther t | ပိ | 17. Father's Name (First, Middle, Last, | | | | ect ec | ary | 18. Mothe | er's Name | (First, Middle, | Maiden S | | 20210 |
| and | ad o ad o ad o |) Be | Vernon Alfred | Hunt | | | | | Ethe | el C | lara G | osne | 11 | |
| Maryland | should Me mark | ဥ | 19a. Informant's Name/Relationship (| Type, Print) | | 19b. Maili | ng Address | (Street a | and Numbe | er or Rura | l Route Number | r, City or | Town, State, | Zip Code) |
| Š | nd 2 in the area of trau | | Lynne Kirby - 1 | Daughter | | 2105 | Cana | da H | ill D | rive | Myers | vill | e, Mar | yland 21773 |
| ē, | s 1 au f Hea item otha | | 20a. Method of Disposition | | ram | e of Dispo | osition (Nar matory or c | ne of other plac | e) 1 | D | ate | 20c. Loc | ation - City or | Town, State |
| E | Page lent o nt: If ry or | | 1 🛱 Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Special | | | | | | | arch | 16,2009 | Wil | liamsp | ort, Marylan |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itams 23a or 28a-f ahow any injury or other traumatic event, Itia Medical Examiner must be notified at ance. | | 21. Signatur of Funeral Sports Life | 13 0 | | | | | | | e, P.A. | | | 0.7505 |
| m | | 10 | (in Al- | X- | | 4 | 25 S. | Con | ococh | neagu | e St. W | illi | amspor | t,MD 21795 |
| | | | 23a. Part1. Enter the disease, or com- shock, or heart tailure. List only | plications that cau | sed the death. h line. | 7.1 | | - 1 | D) | | r respiratory arr | rest. | | Approximate Interval Between Onset and Death |
| 4 | Pnysician | 8 II | Immediate Cause (Final disease or condition | . (01 | ZUNANC | 1 H | ATEN | 4/. | 2504 | et | | | | 5 967 |
| | /Medical | | resulting in death) | Due to (or | as a consequer | nce of): | | | | | | | | |
| 8 | Examiner | | Sequentially list conditions, | b | as a consequer | (). | | | | | | | | |
| | sit s | Examiner | cause. Enter Underlying Cause (Disease or injury | Due to (or | as a conseque | ice oi). | | | | | | | | |
| _ | be executed ician and burial-transit | хап | that initiated events resulting in death) Last | c Due to (or | as a conseque | nce of): | | | | | | | | |
| 8760, | ate be executed hysician and the burial-transit | icai | l | d | | | | | | | | | | |
| 687 | ficate g phys is the | edic | | 0. | | | | | | | | | | |
| Вох | eath certific attending p | Z | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outco | me of pregnanc | | ⊒Ectopic p | rognanou | , | | | 2 | 3d. Date of de | |
| Ä | death certifica le attending ph ed for use as th | icia | in the past 12 months? 1 ☐ Yes 2 ☑No | 4□Pregnar | nt at time of deat | | Other (s) | | | | | | Month | Day Year |
| P.0 | the the | Physician/M | 9 Unknown | 9 Unknow | | | | | | | T 8111 | | | |
| Records, F | 5 5 | by | Part II. Other significent conditions HONTIC TEN | contributing to dea | BES(7 | ing in the i | Inderlying (| PENC | HOLU HOLU | STEM | 230. Did to | | | to the cause of death? Probably 4 Unknown |
| 00 | aw requir is been si 2 should | Completed | | | | | | | | | 24a. Was autop | SV | 24b. Were a | utopsy findings available completion of cause of |
| | Fhe te h | E O | | | | | | | | | perfoi 1 ☐ Yes | med? 2 No | death? 1 □ Ye | |
| Vital | iclan: certifica | Be C | 25. Was case referred to medical examiner? | | | | | | | e of Death | Check on o | ne | | |
| of V | S = = | 101 | 1 ☐ Yes 2 No | | | R/Outpatie | | | 4 🗆 140 | ursing Ho | - | | Other (Sp. | ecify) |
| | | on: | 27. Manner of Delth 1 Natural 5 ☐ Pending | | Day Year) | 8b. Time o Injury | M M | 28c. Injur Wor | yat rk? Yes 2.∐ | | 28d. Describe h | iow injury | occurred | |
| sio | Attanding in death. ector; After by the fune | cat | 2 Accident investigate 3 Suicide 6 Could not | 00 Place 0 | f Injury - At hom | e farm s | | | 163 2 | 100 | 28f. Location (S | Street and | f Number or F | Rural Route Number, |
| Division | T = L | Certification: | 4 Homicide determined | building | g, etc. (Specify) | 0, 14,111, 3 | treot, tactor | y, omco | | | City or Tow | vn. State) | | |
| _ | Hospita 4 hours Funeral | Medicai Co | 29a. Certifier 1 Certifying P (Check only one) | hysicien: To the b miner: On the bas and manne | is of examination | edge, dea n and/or i | th occurred | d at the tir | me, date ar opinion, dea | nd place, ath occurr | and due to the deed at the time, | cause(s) date and | and manner a place, and du | as stated. ue to the cause(s) |
| | To the within 2 To the complete | Me | 29b. Signature and time of certifier |) | \ | | 29 | c. Licens | se number | _ | T | 29d. Date | signed (Mo | hth, Day, Year) |
| | ₩ \$ ₩ Ö | | DITITAL! | FAMILIA | PHYSI | (AN | | 1 | 1701 | 5 | | 4 | 3/13/5 | 009 |
| _ | | | 30. Name and address of person who | completed cause | of death (Item) | (Type | Print) | 11 | . (| , , | . 11 | | 1/11 | 1601- |
| 5 | sH-5 | | STEPHWE ME | TENER, 6 | ms 1 | 3424 | 17 | Au | = 1 | TEI | UI HACK | 7170 | ew W | 011192 |
| | St Regist | ate rar | 31. Date filed (Month Day Year) | 2009 32/8 | gistrar's Signatu | re A. | bash | 1 | / | | | | , | |

| | | - | For State | State of Maryl | • | | of Health and of Death | Mental Hy | giene Reg. No. | 2009 | 09302 |
|-------------------------------------|--|----------------|---|--|---------------------------------------|---------------------------------|--|--|----------------------|---------------------------------|--|
| | _ | | Registrar 1. Decedent's Name (First, Middle, Last | 1) | | | | 2. Date of De | | . 0 0 7 | 3. Time of Death |
| | Physicia | an | | | | | | Month March | Day 1 11 | 2009 | 10:20 am |
| | /Medic | | Ethel Jean SULL 4a. Facility Name (If not institution, give | | | 4b, City, To | wn, or Location of Deat | | | County of Deatl | |
| | Examin | er | | | | | | | | | |
| | | * | Julia Manor Nur: 5. Social Security Number 6. Se | | yrs. last birthday) | | igerstown Year If Under 24 Hrs | 8. Date of Bi | rth | Washin 9. Bird | hplace (State or Foreign |
| | Funeral Director | | | □M 2∏F 79 | Yrs. | Months [| Days Hours Min. | May 1 | ay, Year) 1 191 | Co | ryland |
| | | | Usual Residence of Decedent | | | | | ilay 1 | 1 172 | | Lyrana |
| | yland | | 10a. State 10b. County | 100 | . City, Town or Lo | cation | | | | | 10d. Inside City Limits |
| | Mar | tor | Maryland Washing | ton | Hager | stown | | | | | 1 X Yes 2 □ No |
| | r 28s | Director | 10e. Street and Number | | mage i | 10f. Zip Co | ode | | 10g. Citiz | zen of What Co | untry? |
| | h wit | | 220 Avon Road | | | 217 | 40 | | | USA | |
| | me 2 | Funerai | 11. Marital Status | 12. Was Decedent Ever Armed Forces? | | Was Deceder | nt of Hispanic Origin? (S Cuban, Mexican, Puer | pecify Yes or No | o- ' | 14. Race - Ame | |
| 9 | after or its | 교 | 1 Never Married 27 Married | 1 ☐ Yes 2 ☒ No If Yes, Give | | | | o moan, etc.) | | Black, White | ə, etc. |
| 5-0036 | hours after death with the Maryland tural; or fleme 23s or 28s-f show af Ezan fractinual be codified at | þ | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | 1 ☐ Yes 2√2 | No Specify: | | | Specify: | White |
| 2 | 72 h | Completed | 15. Decedent's Ed (Specify only highest grad | ucation de completed) | | dent's Usual (| Occupation done during most of wo | rkina | 16b. Kir | nd of Business/ | Industry |
| 2 | within 72 ene. then "nat | ğ | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use | retired) | • | | | |
| 2 | ed wi | ပ္ပ | 12 | 0 | Но | memake | | | | r own h | ome |
| 2 | tal H d oth | Be | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | | | | |
| <u>X</u> | should be filed within 72 hours after death with the Marylar ad Mental Hyglens at marked other then "natural", or fleme 23s or 28s-f show marked other then "natural", or fleme 23s or 28s-f show mails event, the Maulisal Example or marked and marked and the marked of t | ဥ | Clyde Fitch Ande | rson | | | Katheri | ne Eliza | abeth | Frush | |
| Maryland 2121 | permit. Pages 1 and 2 should be Department of Health and Menia Important: If Item 27 is marked any injury or other traumatic ev <u>pnce</u> . | | 19a. Informant's Name/Relationship (7 | ype, Print) | 19b. Mailir | ng Address (S | Street and Number or Ri | ural Route Numb | er, City or | r Town, State, Z | (ip Code) |
| 2 | and ealth m 27 | | John L. Sullivan, | | | | | stown. 1 | | | |
| altimore, | of H of H if ite | | 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ | | Ob. Place of Dispo cemetery, cres | isition (Name natory or othe | of er place) | Date | 20c. Lo | cation - City or | Town, State |
| Ē | Pag ment ant: ury c | | 4 □ Donation 5 □ Other (Specify | H | lagerstow | n Crem | natory 3/1 | 2/09 | Hage | rstown, | Maryland |
| at | port port y inj | | 21. Signature of Euneral Service Licen | see ~ | | | | Minnich | | | |
| <u>m</u> | #9 E # 9 | | >CAT! | Muni | | | Wilson Blv | | | n, Mary | land 21740 |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused the one cause on each line. | death. Do not ent | er the mode o | of dying, such as cardia | c or respiratory a | irrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | Fo | u'luce | 10 1 | hrive | | | | Onset and Death |
| 1 | /Medical | | resulting in death) | Due to (or as a cor | nsequence of): | | | | | | |
| п | Examiner | | Conventially list annulations | , (C | 005816 | le | ymphe | mice | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cor | | | | | | | |
| | cuted nd ransi | Examiner | that initiated events | C | | | | | | | |
| o | e exe en al | | resulting in death) Last | Due to (or as a cor | nsequence of): | | | | | | |
| 8760, | Attending Physician: The law requires that the death certificate be executed redeath. sctor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit. | dicai | • | d | | | | | | | |
| 9 | ng ph | 0 | IF FEMALE: | | | | | | | | |
| ŏ | th ce rendi | an/ | 23b. Was decedent pregnant | 23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ | | Ectopic preg | inancy | | 2 | 23d. Date of deli | , |
| Division of Vital Records, P.O. Box | that the death certific ed by the attending p detached for use as | by Physician/M | in the past 12 months? 1 ☐ Yes 2 ☒ No | 4☐Pregnant at time 9☐Unknown | | Other (spec | | | | Month | Day Year |
| o. | at the | بغ | 9 Unknown | | | | | | | | |
| Ś | signed l | ρ | Part II. Other significant conditions co | ontributing to death but no | t resulting in the u | nderlying cau | se given in Part I. | | | | the cause of death? |
| ב | w requir been si should | ed | | | | | | 1 | Yes 2 | JNo 3∏Pr | obably 4 🕅 Unknown |
| ပ္ထ | has be ge 2 sh | ple | | | | | | 24a. Was | an | 24b. Were au | topsy findings available completion of cause of |
| œ _ | The ate h | Completed | | | | | | perf 1 ☐ Yes | ormed? | death? | 2□ No |
| ita | ian: rtifica stor. | Be | 25. Was case referred to medical | | | | 26. Place of De | ath (Check only | | | |
| ~ | ysic direct | 2 | examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 🗌 Inpatient | 2 ER/Outpatier | nt 3 DOA | Other: 4 Nursing H | tome 5 ☐ Res | idence 6 | G ☐Other (Spec | cify) |
| 0 | neral | | 27. Manner of Death 1 ØNatural 5 ☐ Pending | 28a. Date of Injury (Month, Day Yea | 28b. Time o | 280 | : Injury at Work? | 28d. Describe | how injury | y occurred | |
| 0 | ath. or: Af | atic | 2 Accident investigation | | | М | 1 Yes 2 No | | | | |
| <u> </u> | r Atte | tific | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - building, etc. (S) | At home, farm, str | eet, factory, o | office | | Street and | | ral Route Number, |
| ā | ital o rs aft ai Di ed in | Certification; | | | | | | | | | Ji |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page | Medical | 29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone) | ysician: To the best of my niner: On the basis of exa and manner stated. | knowledge, deat mination and/or in | h occurred at vestigation, in | the time, date and place may opinion, death occ | e, and due to the urred at the time | cause(s) date and | and manner as place, and due | stated. to the cause(s) |
| | o the | Me | 29b. Signature and title of certifier | | | 29c. l | License number | | | e signed (Monti | |
| 1 | 120 | |) ()r | M.D | | T | 28345 | - | 3 | 111105 | |
| | DID | | 30. Name and address of person who | | (Item 23a) (Type | Print) | | | | 1 | |
| | 0 | | | TREET | Hage | NS 10 | wnil | 1D, | 217 | 140 | |
| ** | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Registrar's S | Signature | and d | | | | | |

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 5, 5:15 P M 2009 Betty A. Schrack /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mitchelville Prince George's Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/19/1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2∰F Days Hours 84 Yrs. 578-30-2546 Washington D.C Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is markad othar than "naturat", or itama 23a or 28a-f show traumatic evant, its Madical Examinar must be nuillied at Prince George's 1 ☐ Yes 2 No Glenn Dale Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20769 6516 Bell Station Road USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 Midowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is markad othar than "n Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked any injury or othar traumatic evone. Forrest L. Peddicord Grace H. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda I. Schrack/Daughter-in-law 9708 Dixie Ridge Terrace Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cem. 03/10/2009 | Brentwood, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebra /Medical Due to (or as a consequence of) **Examiner** ypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed chronic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Dav 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 2 No 3 Probably 4 ☐Unknown 1 Yes funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed: 1 Yes 2 No 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funaral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2010X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gallart Fox Ln#222 Bowie MO 14300 Arora 31. Date filed (Month, Day, Year) MAR 09 2009 Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Year **Physician** Kevin Stevens A^M 2009 1:37 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days Hours Min. 49 579-86-7072 Yrs **Director** June 30, 1959 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director District Heights Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 6700 Foster Street 20747 Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. **African** 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Be Completed by Specify Specify. American 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elliott Stevens Janie Grey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Michelle Stevens - Wife 6700 Foster Street District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee's Crematory 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or conce. ☐ Burial 2 Cremation 3 ☐ Removal from State Clinton, MD March 16, 2009 ☐Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 21. Signature of Funeral Service Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part/l. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) 2 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran: Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy is certificate has been signed by the atte director, page 2 should be detached for Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 2 No 2 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) old Brough Ave Temple hills and 20748 OUI M·D 31. Date filed (Month, Day, Year) 3. Registrar's Signature State MAR 1 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Maybelle Salter Salter 2009 March 5, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 □XF Days 578-28-7726 83 Jan 29, 1926 South Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 ▼ Yes 2 No Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7206 Drury Court 20785 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married If Yes, Give 7 Year or Dates: 1 □Yes 2 x No Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Years College (1-4or 5+) Domestic Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hezekiah Postell Gertrude Bosier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Williams - Daughter 7206 Drury Court Landover, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Lincoln Mem. Cemetery Mar 12, 2009 Suitland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Part Liber the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fatal Cardiac Arrhythmia disease or condition resulting in death) Due to (or as a consequence of). Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Coronary Artery Disease Due to (or as a consequence of) Hypertension 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 🖺 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner that the death certificate be executed physician and s the burial-transit

attending

for use

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completely

Examine

Physician/Medical

2

Completed

Be

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Certification:

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Department of Health a Important: If Item 27 is any Injury or other tra

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show

natural"

and Mental 27 is marked or traumatic ev

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filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

Physician:

al or Attending F after death. I Director: After

e Funeral filled

3

2

Hospital

To the To the

/Medical

IF FEMALE:

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

28b. Time of Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only

1 XNatural

3 Suicide

2 Accident

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ertifier

6 Could not be determined

29c. License number D65367

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehdi Sattarian, M.D. 3001 Hopsital Drive Cheverly, MD 20785

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per phys. 3/12/09 eb Certificate of Death 1- State #17 per Registrar #29d per 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Firme of Death Day Year **Physician** Richard Lewis Sterling March 9. 2009 6:42 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 66 Somers Cove Apartments Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 219-62-9230 55 Director 02-11-1954 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 □ No Director Somerset Crisfield 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 66 Somers Cove Apartments 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1972-74 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2. No Specify Specify: White Completed by 3 ☐ Widowed 4 Noivorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 none Carpenter Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be F. Delano Catlin Fulton W. Sterling Eula Morgan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eula M. Catlin/Mother 27606 Fairmount Road, Upper Fairmount, MD 21867 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Beechwood Cemetery 03/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Princess Anne, MD 22. Name and Address of Facility Hinman Funeral Home 21 Signature of Funeral/Service Licensee 11673 Somerset Ave., Princess Anne, MD 21853 M00295 23 . Part1. Enter the insease, or complications that caushock, or heart failure. List only one caush on ear whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a conse vience of Examiner resto Gaguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. the as IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital/Records, Completed by 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy Suggeste ea1-e certificate 1□ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: t
completely filled in by the fi investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 03-10-2009 29c. License number 29b. Signature and title of certifier 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month

Year)

12 2009

05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:55 PM ROSS WILSON SCARFF MARCH 16 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) LORIEN - BEL AIR HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 82 219-36-0286 Director Maryland Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 27 No Director Harford Bel Air MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Emmorton Road 21014 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. 1 □ Never Married 2 □ Married áryland 21215-0036 1 □Yes 2 XNo Specify Korea Completed by Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shop Keeper Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estella Ross Scarff Addie ၉ George 19a. Informant's Name/Relationship (Type. Print) Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Pages 1 and 2 Health a 1213 Clearfield Circle Rep. James H. McAteer/ Lutherville, MD. injury or other perimi. Pages 1 and Department of Healt Important: if item 2 any injury or other once. more, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Mem. Gardens: 3/21/2009 Bel Air, Maaryland 22. Name and Address of Facility E.G. Kurtz & Son Funeral 21. Signaffure of Euneral Ser Len Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PROGRESSIVE SUPRANUCLEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duo to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): vision of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) the 1 ☐Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 SEIZURE DISORDER HYPERTENSION Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION 24a. Was an CORONARY ARTERY autopsy DRMENTIA (VASCULAR 1 ☐Yes 2 X No 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2

State Registrar

29b. Signature and title of certific

DHANJANI

30. Name and address

SURESH

31. Date filed (Month

6

f person who completed cause of death (Item 23a) (Type, Print) 40

32. Registrar's Signature

29c. License number D45344

6225, UNION AVE HAVRE DE GRACE, MD 21078

29d. Date signed (Month, Day, Year)

09-02075 Gerald N. Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 3era | ald N. Smith | F | - For State | Maryland / Depa | artment of rtificate of | | Mental H | Reg | No. 20 | 09 0930 |
|------|---|----------------|---|---|----------------------------|--|----------------------------|--|---|---------------------------------|
| Med | Physicia dical Examir | | 1. Decedent's Name (First, Middle,Last) Gerald N. | Smith | | 10 | 1001 | 2. Date of Death Month I March 12, 2 | Day Year | 3. Time of Death 0710 hrs |
| 500 | · k | | 4a. Facility Name (if not institution, give s | | 4 | b. City, Town, or L | | | 4c. County of Dea | |
| | A | 4 | Malcolm Grow Hospital 5. Social Security Number 6. Sex | 7. Age (In yrs. I | last hirthday) | Camp Spring | If Under 24Hrs | . 8. Date of Birth | Prince Georg | |
| | Funeral Director | | · · | 2 F 5 | | Months Days | Hours Min | - | Fore | |
| | any | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Location | on | | | | 10d. Inside City Limits |
| - | Maryland 28a-f show any d at once. | 5 | Maryland Prince Ge | orge's | Temp1e | Hills | - | | | 1 Yes 2 XXIo |
| 6 | the Maryl a or 28a- | Director | 10e. Street and Number 6808 Westchest | er Court | | 10f. Zip Code 20748 | 3 | | g. Citizen of What Co United Sta | |
| | Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 1 Never Married 2 X Married | 2. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No | lf Y€ | s Decedent of Hispes, specify Cuban, | Mexican, Puerto | | 14. Race - Ame White, etc. Specify: | erican Indian, Black, Black |
| | urs afte tural", | 황 | 3 Widowed 4 Divorced If 15. Decedent's Education (Specify only | r Dates: | 16a. Decedent | 's Usual Occupation | on (Give kind of | | 16b. Kind of Business | |
| | D36 thin 72 ho ne. than "na edical Ex | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | Helic | ost of working life. copter In | DO NOT use ret ISTRUCTE | r r | DYN- Co: | rp |
| | 215-0(be filed wintal Hygien ked other | Be Cor | 17. Father's Name (First, Middle, Last) Robert L. Smith, | Sr. | | 1 | 8.Mother's Name Dorothy | e (First, Middle, Ma May | aiden Surname) | |
| | MD 21215-0036 dd 2 should be filed within 7 ulth and Mental Hygiene. m 27 is marked other than aumatic event, the Medica | | 19a. Informant's Name/Relationship (Typ Sonia Smith (Wif | | 19b. Mailing 6808 | Address (Street Westches | ster Cou | ırt, Temp | er, City or Town, Sta 1e Hills, | MD 20748 |
| | Baltimore, Nermit Pages I and Department of Healt Important: If item injury or other tran | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 | Bamaual from State | crematory or oth | ition (Name of cerr ner place) Nationa | Apr Cemete | ilate erv | ეგეტ ^{cation - City} | or Town, State ton, Virginia |
| | altim mit Pa partmen | - | 4 Denation 5 Other Specify: 21. Signature of Funding Service License | | 22. N | ame and Address | of Facility Lee | Funeral | Home, In | c 6633 01d |
| , | | 1 | Mouis A Bad 28a. Part I. Enter the disease, or complic | M00251 | | | | | nton, MD | 20735 Approximate Interval |
| ^ | Physician /Medical yaminer | | failure. List only one cause on each Immediate Cause (Final disease a | ations that caused the death line. Hypertens in the line in the | i ve atheros | | | | | Between Onset and Death |
| | | Jer | | ue to (or as a consequence | of): | | | | | |
| | ed nsit | Exami | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ue to (or as a consequence | of): | | | | | |
| | certificate be executed nding physician and se as the burial - transi | edical | X _{UNPENDED} X | _{амендер} 23а,27 23а, ре | ,permE, er DVR g | g890 4/6 890 4/13 | /09 TT /09 TT/ | PII per | Me g891 5 | /8/09 TT |
| | cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and the strong of the detached for use as the burial - transit | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pre Live birth Pregnant at time of d | 2 Fe | tal death 3 [her (Specify) | Ectopic pregn | ancy | 23d. Date of delive Month | ery Day Year |
| | O. B. tthe de by the ached f | | Part II. Other significant conditions | g Unknown ontributing to death but not | resulting in the u | inderlying cause g | iven in Part I. | 23e. Did tob | pacco use contribute | to the cause of death? |
| | ires that the signed by I be detac | d by | Cirrhosis of t | he liver; di | abetes r | nellitus | | 1 | | robably 4 🗹 Unknown |
| | Records, P.O. Box The law requires that the death crate has been signed by the atte page 2 should be detached for u | Completed | | | | | | 24a. Was a autops perforr | y prior to med? death | |
| | tal Rec cian: The l certificate l ector, page | | 25. Was case referred to medical | | | | of Death (Check | | | 100 2 |
| | Vital F hysician: this certifi | To Be | 1 Yes 2 No | | ER/Outpatient | 0 _ 0 | | | L1 | ner: |
| | n of ading Pl | | 27. Manner of Death 1 X Natural 5 Pending | 28a. Date of Injury (Month, Day,Year) | 28b. Time of I | | y at Work? 'es 2 No | 28d. Describe h | ow injury occurred | |
| | Division of Vital Records, to the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e Place of Injury - At | home, farm, stre | et, factory, office b | uilding, etc. | 28f. Location (So | | Rural Route Number, City |
| | Hospi 24 hou Funer rely fil | | 4 Homicide | n: To the best of my knowle | edge, death occur | rred at the time, da | te and place, an | d due to the cause | e(s) and manner as s | tated. |
| | To the within To the comple | Medical | 29b. Signature and title of certifier | and manner stated. | and/or myosaga | 29c. Licens | | | 29d. Date signed (A | |
| | | =3 | OLMUIL | -IMD | | O.C.I | M.E. | | March 14, 200 | 9 |
| | | | 30. Name and address of person who co | mpleted cause of death (Ite ssistant Medical Exa | | Penn Street, | Baltimore, N | /ID 21201 | | _ |
| | | ate | 31. Date filed (Mohth, Page ear) 2005 | A . | | | | | | |
| | Regis | 14 | | A | CH. TI | | | | | |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) John Edward Spray 2. Date of Death Month Day **Physician** ndût 1600 March 7,21779 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 2 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1X M 2 □ F Hours 214-42-9952 63 1945 Yrs Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shov notified at Director MD Kent Worton 1 Yes 2X No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? , or Items 23a or aminer must be n 11648 Lynch Rd. 21678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⋈ Yes 2 □ No 1963 If Yes, Give Year or Dates: -1967 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Superintendent of Co. Roads Kent County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert C. Spray, Sr. Mary Geneva Woodall 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane A. Spray (wife) 11648 Lynch Rd. Worton, MD. 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If Ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State Chester Cemetery 3/23/09 4 ☐ Donation 5 ☐ Other (Specify) Chestertown, MD. 21. Sign the at Jun-al Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635

23a. Cart Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Care of First. Approximate Interval Between Onset and Death Immediate Cause (Final Se **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease of impery that initiated events Due to (or as a consequence of): Exami law requires that the death certificate be executed physician and as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 \sum Live birth 2 \sum Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) d by the att 1 Yes 2 9 Unknown 2 No P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? The this certificate 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ 6 Other (Specify) 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospital or Attending Fithin 24 hours after death.

the Funeral Director: After 9 5 Pending investigation 1 X Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) es-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert 600 North Wolfe St, Baltimore, MD, 21287 Johns Hopkins Haspital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registral Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:15 AM **Physician** Shirley Swisher 15 2009 march /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day) **Funeral** Months Hours Days rear) 1944 1 □ M 2 🖾 F 64 160-36-3145 June Penna. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, If a IN-Alcel Examiner must be addled at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 X No Greencastle Director Franklin Penna. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 17225 4700 Buchanan Trail West Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claire E. Carbaugh Stanley L. Gelsinger ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 456 Scott Ave. Waynesboro, Pa. 17268 Jerry B. Swisher Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawns Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/19/09 Chambersburg, Pa. 4 Donation 5 DOther (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Zimmerman And Son Funeral Home Carlisle St. Greencastle, Pa. 17225 45 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and use as the burial-tran Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day for in the past 12 men 1 ☐ Yes 2 Ø No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 1 cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1∐Yes 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Mann o Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 21740 SHAHAB 30. Name and address of person who completed ca

2- DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

| | | | _ | Type or Prin | | | | | | | gible. | |
|------------|--|---------------------|---|--|--------------------|--|--|--|---|-------------------------------|----------------------------------|--|
| | | | 1 - For State RegistrarAmended # 3 1. Decedent's Name (First, Middle, Las | 1 Per FCHD | | _ | tificate of | | 03/10/09 2. Date of De | Reg. No | 009 | 0 9 3 1 1 3. Time of Death |
| | Physici /Medio | | SANDRA | CATHER | INE | TOF | REYSON | | Month MARCH | Day | Year | 7:27A M |
| | Examir | ner | 4a. Facility Name (If not institution, given FREDERICK MEMOR | re street and number) RIAL HOSPI | FAL | | 4b. City, Town, FREDER | or Location of De ECK | ath | | unty of Death EDERICK | |
| | Funeral Director | | 302-48-2147 | Gex 7. Age | e (In yrs. I 61 | ast birthday) Yrs. | If Under 1 Year Months Days | | | ay, Year) | Coun | olace (State or Foreign otry) h Dakota |
| | yland how | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | 11 | 0d. Inside City Limits |
| | the Mai | ecto | Maryland Fred | lerick | | | Frederic | 2k | | 10- Citi | of What Coun | 1 □Yes ¾□No |
| | h with | al Dir | 5369 Renn Road | | | | 10f. Zip Code | 21703 | | | ted Sta | • |
| 15-0036 | i 72 hours after death with the Maryland "natural", or items 23a or 28a-f show Lical Eval. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent 8 Armed Forces? 1 □ Yes 2 2 1 If Yes, Give Ye ar or Dates: | Ever in U.S | 1: | Vas Decedent of fYes, specify Cul □Yes 2⊠No | | (Specify Yes or No erto Rican, etc.) | | Race - Americ Black, White, e | |
| က် | 72 Final | Completed | 15. Decedent's Ed (Specify only highest gra | fucation ide completed) | | 16a. Deced | lent's Usual Occu | pation during most of wed) | vorking | 16b. Kind o | f Business/Ind | lustry |
| 717 | filed within Hygiene. other than " | Somp. | Elementary/Secondary (0-12) | College (1-4or 5-+2 | +) | ille. L | | LPN | | | Не | althcare |
| = | eve be | To Be (| 17. Father's Name (First, Middle, Last) Carl Osvold | | | | | | _{ame (First, Middle} herine G | | , | |
| , mar | 12 sho | ľ | 19a. Informant's Name/Relationship (Louis Torreyson / | | | 19b. Mailin | g Address <i>(Stree</i> 9 Renn | t and Number or Road, Fr | Rural Route Numt ederick, | per, City or To MD 217 | wn, State, Zip 703 | Code) |
| more | Pages 1 nent of H ant: If ite ary or otl | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | | Eas | lace of Dispos emetery, crem stern S | sition (Name of patory or other pla Shore Ve | ce) Cem. | Date 3/9/2009 | | on-City or To | |
| g | permit. Departr Importa any inju | | 21. Signature of Funeral Service Licen | isee | H. | . | . Name and Addr | • | Sta Pike, F | | Funeral | |
| | Physician /Medical Examiner | ner | 23a. Par 1. Ever the diseas , o compsh ck, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sc. untially list and the first part of the cause. Enter Underlying Cause (Disease or injury | plications that cause one cause on each line. a. Due to (or as a b. Due to (or as a | a consequ | Do not ente | | ing, such as card | iac or respiratory a | | | Approximate Interval Between Onset and Death |
| ă. | earr certilicate be executed attending physician and for use as the burial-transit | ledical Examiner | resulting in death) Last | cDue to (or as a | a consequ | ence of): | | | | | | |
| O. BOX | To the hospital or Attending Priystcan: The law requires that the death definitions within 24 hours after death. To the Funeral birector: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □Unknown | 23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown | 2 🗆 Fetal | death 3 | Ectopic pregnan Other (specify) | су | | | Date of delive Month | ry Day Year |
| ecords, P. | quires that in signed by uld be deta | þ | Part II. Other significant conditions of | ontributing to death bu | it not resu | Iting in the un | derlying cause gi | ven in Part I. | | | | e cause of death? |
| n Reco | To the hospital or Attenuing Priystoan: The law requires that the or within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | Completed | | | | | | | 24a. Was auto perfo | | prior to con death? | osy findings available npletion of cause of 2 \(\subseteq No \) |
| <u> </u> | certific | Be | 25. Was case referred to medical examiner? | Hospital: | | | Ott | 205: | eath (Check only o | one) | | |
| 5 2 | g rnya ter this ieral di | n: To | 27. Manner of Death | 28a. Date of Injur | y | ER/Outpatient 28b. Time of | 28c. Inju | 4 ☐ Nursing | Home 5 ☐ Resi | | |) |
| VISION | death. ctor: After i y the funera | Certification: To | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | | | Injury | M 1 | rk?]Yes 2 □ No | 29f Location (| Ctroot and No | emboros Burni | Route Number, |
| 2 | ital of a irs after ral Dire | Certif | 4 ☐ Homicide determined | building, etc. | . (Specify, |) | | | City or To | wn, State) | | · |
| | e nusp 24 hou e Funei letely fil | Medical | 29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam | ysician: To the best on niner: On the basis of and manner state | examinati | vledge, death ion and/or inv | occurred at the t estigation, in my | ime, date and pla opinion, death oc | ce, and due to the curred at the time, | cause(s) and date and plac | manner as store, and due to | ated. the cause(s) |
| i | within To the | Me | 29b. Signature and title of certifier | 1.0 | | | 29c. Licens | se number | | 29d. Date sig | ned (Month, E | Jay, Year) |
| | 00 | | 30 Name and address of parson who | completed cause of #1 | ath /Itam | 23a) (Tunn F | | 67210 | - | 3/1 | 1/09 | |
| | 0 | | 30. Name and address of person who de Rom 17 Childs | AT 400 | 200 | MAG | Stree | + Fre | ederich | Z W | Jarylo | und 21701 |
| | Sta Registra | | 31. Date filed (Month, Day, Year) | 32. Registed | s signati | <i>A</i> . , | bartel | - MAR 1 | 0 2009 | Densun | U A. | parked |

Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARIE THOMAS March 2009 0325 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 9 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}940 1 □ M 2 1 F Maryland 212-40-2158 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Examiner must be notified at once. 23a or 28a-f show tv∑Yes 2 □ No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Glenwood St. Apt 404 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th 0 Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall Thomas Sadie Cook ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 7836 Park West Dr. Apt 103 Glen Burnie, Md Rochelle Weems (Granddaughter) 20a. Method of Disposition 20c. Location - City or Town, State Date Place of Dispession (Name of cemetery, demandry or other place) 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 3-9-09 Annapolis, Md. 4 Donation 5 Dother (Specify) Miname Aces cof ScilitSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Rea M00483 B 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRICULAR FIBRILLATION disease or condition resulting in death) MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð RENAL FAILURE (CHRONIC) 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □ Yes 2 **N**No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; d in by the 3 D Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D66753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parliway, Tim Capstack 2001 Medical 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 200^{Ye al} **Physician** MARCH 4 10:45 A M HENRIETTA E. THOMAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S LAUREL REGIONAL HOSPITAL LAUREL 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUNE 1 1915 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □√F MARYLAND JUNE Yrs 214-30-2121 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Pedical Exp. its could be notified at once. 14 Yes 2 □ No Director MD PRINCE GEORGE'S LAUREL 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number USA 11731 SOUTH LAUREL DRIVE # 624A 20708 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC PRIVATE 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BURLEY **EMMA** STEPHEN THOMAS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7142 MAHOGANY DRIVE HYATTSVILLE, MARYLAND 20785 LAVINIA THOMAS/GRANDDAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 3/11/2009 LANDOVER, MARYLAND 4 □ Donation 5 □ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Foneral Service Licens 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed CORONARY ARTERY DISEASE and the burial-trar Due to (or as a consequence of): physician Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>^</u> DEMENTIA 3 Probably 4 H Unknown 1 ☐ Yes 2 ☐ No Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 🖾 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, thours after death.
uneral Director: A 24 hours To the Hosp within 24 ho To the Fune completely f

Medical Registrar

State

29a. Certifier

(Check only

29b. Signature and title of certifie

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Mpnth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HENRY S. WILLNER M.D. 7300 VAN DUSEN ROAD LAUREL, MARYLAND 20707

31. Date filed (Month, Day, Year)

32. Registrar's Signature alle MAR 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 03 07 2009 23:30 Michael Vo1k Richard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 220-60-1249 21 1953 Cheverly, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Prince Georges Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20782 6213 41st Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify à 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7% in and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Plumber Trade/Local Union # 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Andrew Volk, Sr. Irene Marie Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I Tamrica McCarthy - Stepdaughter 658 209th Street Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Buria! 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Crematory 3/16/2009 Brentwood, MD Ft. 22. Name and Address of Facility Ft. Lincoln Funeral Home, 21. Signature of Funeral Service Licenses 3401 Bladensburg Road Brentwood, MD 20722 well Montgomery 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of t certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred lospital or Attending P thours after death.
-uneral Director: After tely filled in by the funeral After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) 145660

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Registrar

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30. Name and address of person who completed cause of death (I)em 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 2 000 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** March 4, 6:26 P M Anne Marie Wojcik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg 20009 Giantstep Terr Date of Birth Month, Day, Y Jan 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Year) 1937 **Funeral** Days Hours Washington, D¢ 1 □ M 2 🖸 F 72 579-46-2534 Director Usual Residence of Decedent 1.2 should be filed within 72 hours after death with the Maryland 'n and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the McJical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20886 USA 20009 Giantstep Terr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □ No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Gov't Elementary/Secondary (0-12) College (1-4or 5+) Census Bureau 12 Statistacal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donohue Beck Anna. Charles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 20009 Giantstep Terr. Gaithersburg, MD Kathleen Seipp (daughter) tem 27 other to Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marate 9 Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) F permit. Page Department o Important: If any injury or 2009 Clinton, MD Resurrection Cemetery Aneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA cary J. Gori 20736 Owings, MD 8125 Southern Maryland Blvd. 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Years **Physician** Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-tra Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2**X** No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, sign 1XX Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy , page performe 1 ∐Yes 2X No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Hospital or Attending 1 ₩ Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in death. investigation 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061083 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drw 7 Thambi, MD 9707 Medical Center Drive Rockville, MD 32. Registrar Signature 31. Date filed (Month, Day, Year) State MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | 1 | State of Maryland / | | rtment of H <i>tificate of L</i> | | - | giene Reg. No. 20 | 09 | 09316 |
|----------------------------|---|-------------------|--|---------------------|--|--|---------------------------------|-------------------------------|---|---|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | - Turk | 2. Date of Dea | ath | | 3. Time of Death |
| | Physician //Medical Examiner Marvin Warren Wagner 4a. Facility Name (If not institution, give street and number) | | | | Marc Marc | | | 3 2 | 009 | 6:15 PM |
| | | | | | 4b. City, Town, or Location of Death | | | 4c. County of Death | | |
| | | | 7 East Washington St. | | Hagersto | | | | _ | County |
| | Funeral | | 5. Social Security Number 216−36−5543 6. Sex 1 M 2 □ F 6. Text 1 M 2 □ F 6. Sex 1 M 2 □ F | birthday) _ Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birt (Month, Da | th y, Year) | 9. Birth | place (State or Foreign ntry) |
| | Director | - | 216-36-5543 NAM 2 67 | 113. | | | June 2 | ,1941 | Balt | imore, MD |
| | land ow | Ì | 10a. State 10b. County 10c. City, To | own or Loc | ation | | | | | 10d. Inside City Limits |
| | Mary a-f sh | ģ | Maryland Washington County Hage | erstov | ٧n | | | | | 1∭XYes 2 ☐ No |
| | or 28% | Director | 10e. Street and Number | | 10f, Zip Code | | | 10g. Citizen of | What Cou | ntry? |
| | th wit | | 7 East Washington St. | | 21740 | | | U.S.A. | | |
| | r dea | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No | 13. W | as Decedent of His Yes, specify Cubar | spanic Origin? (Sp n, Mexican, Puerto | ecify Yes or No Rican, etc.) | - 14. Ra | ace - Ameri ack, White, | |
| 30 | , or it | by F | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates: | 1 | □Yes 2□XNo | Specify: | | Spec | ify: Wh | iite |
| 3 | filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show art, the Mydical Evandra must be notified at | ed t | | 6a. Deced | ent's Usual Occupa | ation | | 16b. Kind of I | 3usiness/Ir | ndustry |
| 21215-0036 | in 72 n "na | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give k life. D | kind of work done d OO NOT use retired) | uring most of work) | ing | Automo | bile | Dealership |
| 212 | d with giene ir tha | ĕ | 12 | Sales | nan | | | | | |
| | ~ = 0 \$ | æ | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | | | |
| Z | should be filed wand Mental Hygie s marked other t umatic event, th | 卢 | Henry Wagner | | | Ida Evel | | | | |
| Jar | 2 sho and ls m raum | | | | g Address <i>(Street a</i> Box 153 | | | | ı, State, Zı | p Code) |
| e, | ages 1 and 2 should be nt of Health and Ments t: If item 27 Is marked r or other traumatic e | | | | | | Date | 20c. Location | ı - City or T | own, State |
| Baltimore, Maryland | Pages nent of I int: If its iry or o | | 1 Burial 2 M Cremation 3 Hemoval from State | | sition (Name of natory or other place | i | 2000 | C | | M11 |
| | permit. Pages Department of Important: If it any injury or once. | i | 4 □ Donation 5 □ Other (Specify) Smit | | rg Cremat Name and Addres | | -2009 | | | Maryland eral Home |
| Ba | Department any any once | | Kaithe Ballano | | 331 Easte | | _ | | - | |
| | | | 23a. Part 1. Enter the disease, or complications that caused the death. | | | | | | J., 1 | Approximate Interval Between |
| 1 | Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final | 1 10 | tructive | Policer | ary Di | . 01462 | | Onset and Death |
| N. | /Medical | | disease or condition resulting in death) a. Due to (or as a consequence | | Tractive | INTINION | 7 3/1- | 3600 | | |
| | Examiner | | Sequentially list conditions b. | | | | | | | |
| | ار بر ان چ | Examiner | Sequentially list conditions, if any, reading to intrinsulate cause. Enter Underlying | de ul): | | | | | | |
| | ecute and trans | xam | Cause (Disease or injury that initiated events resulting in death) Last | ce of): | | | | | | |
| 8760, | ficate be executed physician and s the burial-transit | | | | | | | | | |
| 387 | ficate phys s the | edical | d | | | | | | | |
| × | leath certific attending p | Š | IF FEMALE: 23b, Was decedent pregnant 23c, If yes, outcome of pregnancy | | | | | 23d. E | Date of deliv | very |
| P.O. Box | death certifi e attending d for use as | Physician/Me | in the past 12 months? 1 \(\subseteq \text{Vos.} 2 \subseteq \text{No.} \) 4 \(\subseteq \text{Pregnant at time of deat} \) | | Ectopic pregnancy Other (specify) | / | | N | Month | Day Year |
| 0 | t the by th tache | hys | 9 ☐ Unknown | | | | | | | |
| | res that the de signed by the a be detached to | by F | Part II. Other significant conditions contributing to death but not resultin | ng in the un | nderlying cause give | en in Part I. | | | | the cause of death? |
| g | w require s been sig should b | ted | Hypertension | | | | 1 🖫 | Yes Z NO | 3 FIC | obably 4 Unknown |
| S | e law r has b | eldu | | | | | 24a. Was | psy | Were aut prior to condeath? | opsy findings available completion of cause of |
| <u></u> | : The cate h | Completed | | | | | 1 □Yes | 2 No | 1 ☐ Yes | 2 □ No |
| Division of Vital Records, | ding Physician: The In. After this certificate hit funeral director, page | Be | 25. Was case referred to medical examiner? Hospital: | | Othe | 26. Place of Deat | | | | |
| ō | Phys r this ral dii | ٦. | 1 Tes 2 No 1 Inpatient 2 ER | Bb. Time of | IL 3 LI DOA | 4 LI Nursing Ho | | how injury occ | | cify) |
| Ou | ding h. Afte fune | tion | 1 ☐Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation | Injury | | (? Yes 2 □ No | | | | |
| /isi | or Atteno after death Director: | iţica | 3 Suicide 6 Could not be 28e. Place of Injury - At home | e, farm, stre | eet, factory, office | | 28f. Location (City or To | Street and Nur | nber or Ru | ral Route Number, |
| á | tal or rs afte al Dire | Certification: To | 4 Homicide determined building, etc. (Specity) | | | | Oily of 70 | wii, Otalo) | *** | |
| | To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | | 29a. Certifier 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination | edge, death | occurred at the tir | ne, date and place | , and due to the | cause(s) and date and plac | manner as e, and due | stated. to the cause(s) |
| | To the H within 24 To the F complete | l edical | one) and manner stated. | | | | | 29d. Date sign | | |
| | 5 with 50 cor | Σ | 29b. Signature and title of certifier | | 29c. Licens | 2 | | zou. Date sigi | - 1 . 1 | 7.009 |
| | | | | 0a) /T = a | | 57285 | | | 10/5 | 447 |
| 5 | 4-2 | | 30. Name and address of person who completed cause of death (Item 23) | West | and ctions | + 4102 | Huma | rstown | MN | 71740 |
| | Sta | ite | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | A A A | 1 4102 | Itale | ·slmn | (1) | 1 -11 |
| | Regist | | WAT 11 2000 14 | A A | B. D. Mari | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Drown aters 8, 2009 ber eb. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Street ambridge If Under 24 Hrs. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Security Number **Funeral** Pennsylvania Months Days 12-40-9235 1 ☐M 2 ☐ F 6 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, Tra Madical Examitment and to collical at 1 Yes 2 No Funeral Director Mbrid 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Street death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 196 I 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ▼Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event. It is Mental to the Mental Item Elementary/Secondary (0-12) College (1-4or 5+) Canning Indu 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Waters Opher Houston ٩ Irene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nam-Relationship (Type. Print) MD, 2/613 Cambri 14 Road dge 20d. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 09 Bethel 4☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility
Henry Funeral Home, P. A.
510 Washington St. C Name and Address of Facility 21. Signature of Funeral Service Licensee MD. 21613 23a. Pant. Enter the disease, or complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final abstrowe We CLYMIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner esquentially liet on ultime, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the buriat-tran Due to (or as a consequence of) Box 68760, Physician; The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year signed by the a d be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an cate has bage 2 s autopsy performed certificate 1 ∐Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ∃No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN 11HANWY 503 MARRIAGE

Registrar

State

31. Date filed (Month

32. Registrar's Signature

| | | | For | State | of Mary | land / Depa | | | | lental Hy | giene | | | |
|---|--|--|--|---------------------------------------|----------------------|---------------------------------------|----------------------------------|---|------------------------------------|-----------------------------------|---|--|-------------------------|--|
| | | Togista: | | | | | rtificate of Death | | | | Reg. No. 2 1 1 9 1 9 3 1 8 | | | |
| | 1. Decedent's Name (First, Middle, Last) Physician | | | | | | | | 2. Date of De Month | ath — 1 Day 7 | Year | 3:-Time of Death | | |
| | /Medical Ellen Louise warren | | | | | 4h City To | wn or Loca | ation of Death | March | | 2009 nty of Death | 11:19 p ^M | | |
| | Examin | Examiner 4a. Facility Name (if not institution, give street and number) Union Hospital | | | | | Elktor | | anon or boarn | | Cec | | | |
| | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | | | | If Under 1 | ear If U | Under 24 Hrs. ours Min. | 8. Date of Bir (Month, Da | th | | ace (State or Foreign | | | |
| ю | Director | | 089-26-9327 | 1□ M 2×1F | 92 | Yrs. | MOTHERS | ays III | July Will. | August 2 | | Count | Canada | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | / | 10 | c. City, Town or Lo | cation | | | | | 10 | 0d. Inside City Limits | |
| | Mary I-f shi | 호 | MD Cecil | | | Elkton | | | | | | | 1 Yes 2 □ No | |
| | th the or 28a | Director | 10e. Street and Number | | | | 10f. Zip C | ode | | | 10g. Citizen | of What Coun | iry? | |
| | 23a ust b | <u>a</u> | 405 East Pulaski Hy | vy. | | | 2192 | | | | USA | | | |
| | er de items | Funeral | 11. Marital Status | 12. Was Dec | orces? | in U.S. 13. | Was Deceder If Yes, specify | t of Hispan Cuban, M | nic Origin? (Spe exican, Puerto | ecify Yes or No Rican, etc.) | - 14. F | Race - America Black, White, e | | |
| 36 | be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitled at | 5 | 1 Never Married 2 Mai 3 Widowed 4 Divorce | If Yes, G | | | 1□Yes 2 | No Sp | ecify: | | Spe | ecify: Wh | ite | |
| 9 | '2 hou | Completed | 15. Decede | nt's Education | | 16a. Decedent's Usual Occupation | | | ina | 16b. Kind of Business/Industry | | | | |
| 215 | ithin 7 ne. nan "r Med | nple | Elementary/Secondary (0-12) | est grade completed, College | 1-4or 5+) | 1 | | rind of work done during most of working O NOT use retired) | | | | | | |
| 7 | led w hygier her th | | 5 17. Father's Name (<i>First, Middle</i> | Loct | - | Assist | ant Mana | | Mothor's Name | (First, Middle, | Hotel | name) | | |
| and | d be feathall be contact of the cont |) Be | James Warren | , Lasij | | | | | | • | waiden Sun | iaine) | | |
| Maryland 21215-0036 | shoul nd Me mark | 유 | 19a. Informant's Name/Relation | ship (Type. Print) | | 19b. Mailir | ng Address (S | | sabella Bu | if reage al Route Numb | er, City or Tov | wn, State, Zip | Code) | |
| ž | and 2 alth a 1 27 Is er trau | | Charles H. Breza, J. | r./Grand-Nepl | iew | 122 V | Vashingte | n Ave. | , Elkton, I | MD 2192 | 1 | | | |
| altimore, | es 1 a of He of Hem | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation | 3 □Removal from | | 20b. Place of Dispo cemetery, crei | sition (Name matory or other | of er place) | | Date | 20c. Locatio | on - City or To | vn, State | |
| Ĕ | Pag tment tant: | | 4 □ Donation 5 □ Other (| Specify) | 0.0.0 | Gilpin Man | | | | 13, 2009 | Elkt | on. MD | | |
| Bai | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Many and Mice | Licensee | | | 2. Name and | | , | | | | | |
| | | | 23a. Part1. Enter the disease, o | r complications that | caused the | | | | | | | ., Elkton, | MD 21921 Approximate | |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Physician COLOGO BYP Heart For July | | | | | | 148 | | Interval Between Onset and Death | | | | | | |
| | /Medical | | Immediate Cause (Final disease or condition resulting in death) a. END STAGE CONGOSTIVE HEART FAILUYE Due to (or as a consequence of): | | | | | | | | | | | |
| | Examiner | | Sequentially list conditions, b. | | | | | | | | | | | |
| | ed sit | ine | Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 8760, | e be e sician burî | dical E | | d | | | | | | | | | | |
| 9 | tificat ng phy as the | ledi | | | | | - | | | | | | | |
| Division or Vital Records, P.O. Box | uires that the death certific signed by the attending I d be detached for use as | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, ou 1□Live | | | JEctopic preg | nancy | | | 1 | Date of deliver | , | |
| 0 | ne dea the at hed fc | /sici | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Preg 9□Unki | nant at time nown | e of death 5 | Other (spec | fy) | | | | Month | Day Year | |
| ٩. | that the ed by detac | Ph | Part II. Other significant condit | lons contributing to o | leath but no | ot resulting in the u | nderlying cau | se given in | Part I. | 23e. Did to | obacco use c | acco use contribute to the cause of death? | | |
| ds | luires sign lid be | d b | | | | | | | | 1 | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown | | | |
| Ö | sw requir | Completed | | | | | | | | 24a. Was | an 24 | b. Were autop | osy findings available | |
| <u>~</u> | siclan: The law certificate has t irector, page 2 s | шо | | | | | | | | autop perfo 1⊟ Yes | rned? | death? | pletion of cause of | |
| /ita | clan: ertifica ector, | BeC | 25. Was case referred to medical examiner? | | , | | | 26. | Place of Death | (Check only o | | | K | |
| <u>~</u> | Physic this c | 2 | 1 Yes 2 No | (- | | 2 ER/Outpatien | | | | me 5 Resid | | |) | |
| on | ding F | ion: | 27. Manner of Death | 28a. Date ng (Moi igation | oth, Day Ye | 28b. Time of Injury | M 280 | Injury at Work? 1 ☐ Yes | | 28d. Describe I | now injury occ | curred | | |
| <u>IS</u> | Atten r deatl sctor: by the | fical | 3 ☐ Suicide 6 ☐ Could | not be 28e. Plac | e of injury - | At home, farm, str | | | | | | mber or Rural | Route Number, | |
| Ö | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page | Certification: | 4 ☐ Homicide determ | Dulic | ling, etc. (S | респу) | | | | City or Tov | vn, State) | | | |
| | Hospi 4 hour Funer ely fill | cal | (Check only 2 Medica | ng Physician: To the Examiner: On the | e best of m | y knowledge, deatl | n occurred at vestigation, ir | the time, d | ate and place, n, death occur | and due to the ed at the time. | cause(s) and date and plac | manner as sta | ated. the cause(s) | |
| | thin 2, the I thin 2, the I | Medical | one) . 29b. Signature and title of pertifi | and mai | ner stated. | | | icense nun | | | | ned (Month, L | Y | |
| | N I W | | 1. Charles and the or partition | all 1 | 0 | | | | | | | | , | |
| | 6 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Or Timothy O DONNE L(M.) I Jut 32 Peoples Plata NOWAYK 1) | | | | | | | 2009 | | | | | |
| | 2 | Dr. Timothy O' DUNNELL M.D. Pute 32 Peoples Plata NOWAYK De 19 | | | | | | 1)e 19702 | | | | | | |
| 20 ² 0 | Sta | | 31. Date filed (Month, Day, Year | . / | Registrar's | Signature Span | 1.1 | | , | | | | | |
| | Registr | ar | MAR 11 | 2009 1200 | un | p. pau | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2.234 M 03-01-2009 hristina /Medical 4c. County of Death 4b. City, 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner G fon 1 Year | If Under 24 Hrs. If Under 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. Director Delaware Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, it is Medical Experiment in its to realined at 1**/2**Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other than "natural", or items 23a or 2 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should nent of Health and Mer 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Ponation √5 Other (Specify) 03 15 ☐ Other (Specify) BOX 259 ton DE 19805 23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence on burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo 1 ∐Yes 2 🔼 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy perform Ins Chaon? 1 ☐ Yes 2 XNo 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural ours after death.
neral Director: A death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier MD Hopitalink 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 RAJAI SHAH

State

Registrar

31. Date filed (Month, Day, Year)

MAR 11 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 4: 05AM 0009 **Physician** nae /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 🛛 M 2 🗆 F 9/24/1931 California 77 218-26-4707 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any Injury or other traumatic event, the Medical Examiner must be notified? Director Prince George's Riverdale Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 20737 USA 6016 Mustang Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Year or Dates: 1951-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Information College (1-4 or 5+) Elementary/Secondary (0-12) Technology Computer Operator years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be <u>Virginia Julia Schmidt</u> Robert James Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cormer Ct., Apt. 303, Timonium, MD 21093

f Disposition (Name of Date 20c. Location - City or Town, State Louise A. Welch/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 3-12-09 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Milleler 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? for Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 4 Unknown 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed: 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ρ after death.

Director: After this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 🗌 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital of thin 24 hours at the Funeral D To the

Registrar

Medical

4 Homicide

29b. Signature and title of certifier

29a. Certifier (check only

Bent 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature MAR U 9 2009

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 00

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

09321 State of Maryland / Department of Health and Mental Hygier Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Ana Rosa Weaver March 5, 2009 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gladys Spellman Nursing Home Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)

Months Days Hours Min. August 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) Year 1 □ M 2 🖾 F Months 86 216-82-8582 Director Columbia (S.Am.) Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Madical Exemitmer must be notified at 1 X Yes 2 No Directo Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a or 2409 Cheverly Avenue 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or ite 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Columbian þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Weaver / Husband 2409 Cheverly Avenue, Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny Injury or ot once. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/11/2009 Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Leges Gasch's Funeral Home, P.A. Hyattsville, MD 20781 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 ensilvote Cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (vi as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed -transit that initiated events attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 ☐ № 6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1- Natural death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tothning

8 3 University Bit D Earl Silver Shop M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State pares Registrar

| | | | For State | State of Ma | ryland / Dep | artment of F rtificate of I | | | 71111 | 9 09322 | |
|----------------------------|--|-------------------|--|---|---|---|---|---|--|---|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | | | | Death | 2. Date of Dea | neg. No. | | |
| | Physicia | | Vera I. | | | Month | Day Year | | | | |
| 1. | /Medic Examin | | 4a. Facility Name (If not institution, giv | re street and number) | | 4b. City, Town, or | Location of Dea | <u> March 5</u> | 4c. County of De | 3:00 P M | |
| - | LAGIIIII | - | Clinton Nursing | & Rehab Ce | nter | Clinto | n | | Prince (| George's | |
| | Funeral | | 5. Social Security Number 6. S | | (In yrs. last birthday) | | If Under 24 Hrs Hours Min | | h y, Year) 9. B | irthplace (State or Foreign Country) | |
| | Director | | 220-20-4290 Usual Residence of Decedent | | 81 Yrs. | | | May 22 | 2, 1927 Ma | ryland | |
| | /land | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. Inside City Limits | |
| | a-fsh | ctor | Maryland Howard | 1 | Colum | nbia | | | | 1 XYes 2 ☐ No | |
| | ith the | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What C | Country? | |
| | s 23a | | 10166 Pasture G | | | 2104 | | 2 | United St | | |
| | item item | Funeral | 11. Marital Status1 ☐ Never Married2 ☐ Married | 12. Was Decedent E | | Was Decedent of H If Yes, specify Cuba | an, Mexican, Puei | to Rican, etc.) | 14. Hace - An Black, Wh | nerican Indian, ite, etc. | |
| 21215-0036 | urs af | by | 3√2 Widowed 4 □ Divorced | 1 ∐Yes 2 No If Yes, Give Year or Dates: | | 1 □Yes 2 No | Specify: | | Specify: | Black | |
| 2-0 | 72 hor | Completed by | 15. Decedent's E (Specify only highest gra | ducation | | edent's Usual Occup | | nkina | 16b. Kind of Busines | s/Industry | |
| 21 | ne. | mpl | Elementary/Secondary (0-12) | 5+ College (1-4or 5+ | lifo | Principa | 1) | 9 | Govern | Government | |
| d 2 | iled w Hygie ther t | ပ္ပ | 17. Father's Name (First, Middle, Last | | | TTIMOTPO | | me (First, Middle, | Maiden Surname) | | |
| Maryland | should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the "Kediest Eventher must be redified at | To Be | Thomas Page | | | | | Marie Ri | | | |
| ary | shou and M s mar umat | - | 19a. Informant's Name/Relationship | Type. Print) | 19b. Maili | ng Address (Street | and Number or F | tural Route Numbe | er, City or Town, State | , Zip Code) | |
| Σ, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanuiner must be rectified at once. | | Bronwyn M. Small | ey - Daught | | | | | MD 21044 | | |
| Baltimore, | | | 20a. Method of Disposition 1 Burial 2 Tremation 3 D | Removal from State | 20b. Place of Dispo cemetery, cre | osition (Name of matory or other plac | :e) | Date | 20c. Location - City of | r Town, State | |
| Ħ | it. Pa rtmen rtant: njury | | 4☐Donation 5☐Other (Special | fy) | Lee's Cr | ematory 2. Name and Addre | | ch 11, 20 | | | |
| Ba | Depa Impo any I | | 21. Sign tur of Funeral Service Lice | Sied B. | 411 | | _ | | uneral Hom hington, D | | |
| | | | 23a. Part 1. Enter the disease, or comshock, or heart failure. List only | plications that caused to | the death. Do not en | | | | | Approximate Interval Between | |
| 1 | Physician and Medical Examiner bhysician and street private in the | | Immediate Cause (Final disease or condition resulting in death) | Athei | coscleroti | .c Cardiov | ascular | Disease | | Onset and Death | |
| а | | | Due to (or as a consequence of): Atrial Fibrilation | | | | | | | | |
| | | ē | Sequentially list conditions, | | | | | | | | |
| | | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | Demen | ntia | | | | | | |
| Ö, | cate be executed physician and the burial-transit | Exc | Due to (or as a consequence of): | | | | | | | | |
| 8760, | cate b | dicat | | d | | | | | | | |
| | eath certific attending p for use as | /Me | IF FEMALE: | 23c. If yes, outcome of | f pregnancy | | | | OOd Date of d | all and | |
| Box | atten for u | sician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 2 | Fetal death 3 | ☐ Ectopic pregnanc☐ Other (specify) | у | | 23d. Date of d Month | Day Year | |
| P.O. | that the de ned by the detached | Physi | 1 ☐ Yes 2 🛣 No 9 ☐ Unknown | 9 Unknown | | | | | | | |
| S, F | res that signed be det | by P | Part II. Other significant conditions | contributing to death but | not resulting in the ι | inderlying cause give | en in Part I. | 23e. Did to | obacco use contribute | to the cause of death? | |
| ord | w require been si should b | ted | | | | | | 1 □ Y | ′es 2 📉 No 3 🗌 I | Probably 4 🗌 Unknown | |
| Rec | has has | Completed | | | | | | | 24a. Was an autopsy performed? 24b. Were autopsy finding prior to completion or death? | | |
| ţ | | a) | 25. Was case referred to medical | | | | 26. Place of De | 1 □Yes ath (Check only o | | es 2 🗆 No | |
| > | \$.s = | To B | examiner? 1 ☐ Yes 2 ĀNo | Hospital: 1 ☐ Inpatier | nt 2 ☐ ER/Outpatie | nt 3 DOA Oth | er: 4X Nursing i | Home 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| ouo | ding L Afte fune | tion: | 27. Manner of Death 1 | | | | | | 28d. Describe how injury occurred | | |
| Division of Vital Records, | tten deatl ctor: y the | Certification: To | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | reet, factory, office | | 28f. Location (S City or Tow | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | |
| 1 | To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by | Medical (| 29a. Certifier 1 Certifying Fig. (Check only one) 2 Medical Example 1 | nysician: To the best of miner: On the basis of and manner stat | examination and/or in | th occurred at the tin nvestigation, in my o | me, date and place pinion, death occ | ce, and due to the curred at the time, | cause(s) and manner date and place, and du | as stated. ue to the cause(s) | |
| | To the within To the compl | Me | 29b. Signature and title of certifier | do. 1 | <i>f</i> | 29c. Licens | e number | | 29d. Date signed (Mor | | |
| | 8 | | 1 Jans | 1101111 | m. | 5405 | 4 | 1 | narch, | 0109 | |
| | 00 | | 30. Name and address of person who | / | , | Print) | | | | 1 | |
| | Sta | te. | Arastoo Yazdani | M.D. 9135 32. Registra | Piscataw r's Signature | ay Road # | 235 Clir | nton, MD | 20735 | | |
| | Registr | - | 31. Date filed (Month, Day, Year) | Lenga | A. par | | | | | | |

| Bobby Craig Wishar | d S 1- For State Registrar | | nd / Departmen Certificate | | | Hygiene | g. No. 20 | 09 0932 |
|---|---|---------------------------------|---|----------------------------------|--|--|--------------------------|--|
| Physician/ Medical Examiner | Decedent's Name (First, Midd Bobby | Craig | Wishard | | | 2. Date of Deat Month March 13, | h | 3. Time of Death 1039 hrs |
| | 4a. Facility Name (if not instituti 185 B Court | on, give street and nur | mber) | 4b. City, Tow Lothian | n, or Location of De | ath | 4c. County of I | |
| Funeral | 5. Social Security Number | 1 | 7. Age (In yrs. last birthda | y) If Under 1 | | din | | Birthplace (State or Foreign Country) |
| Director | 577-96-2687 Usual Residence of Decedent | 1 X M 2 F | 42 | Yrs. | Sayo House | Feb.1 | 8,1967 | Maryland |
| a n | 10a. State 10b. County | | 10c. City, Town or L | | | | | 10d. Inside City Limits |
| ar sho | MD Char | les | Waldorf | 10f. Zip Co | MA | 140 | ng. Citizen of What | 1 Yes 2XXNo |
| the Marylanc as one 28a-f shuffled at one Director | 2135 Crain | Highway | | | 0601 | | U. S | · |
| after death with the Maryland air, or items 23a or 28a-f show mer must be motified at once. | 11. Marital Status 1 Never Married 2 | | | | of Hispanic Origin? (Cuban, Mexican, Pue | | 14. Race - A White, e | American Indian, Black, etc. |
| | | 1 Yes | 2 <u>X</u> X No | Yes 2X | No specify: | | Specify: | White |
| | 15. Decedent's Education (Sp | | durir | | cupation (Give kind | | 16b. Kind of Busin | |
| 5-0036 ed within 72 hour lygiene. other than "uatt the Medical Exar | Elementary/Secondary (0-12 1 0 |) College (1- | -4 or 5+) | o Mecha | | | Self-E | boyolan |
| 11215-0036 Idbe filed within 72 hours after denial Hygiene. narked other than "natural"; event, the Medical Examiner o Be Completed by | 17. Father's Name (First, Middle | | | 0 1100110 | 18.Mother's Na | ime (First, Middle, N | Maiden Surname) | moroyeo |
| 2121 2121 Suld be fi Mental I marked ic event, | Robert Cra 19a. Informant's Name/Relation | ig Wishar ship (Type, Print) | | lailing Address | Jean Street and Number | Marie 1 or Rural Route Nurr | | State, Zip Code) |
| MD nd 2 sho afth and afth and after | Bernard Wis | hard/Brot | | | in Highw | | | |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "uatuu injury or other trainmatic event, the Medical Exam | 20a. Method of Disposition 1 Burial 2XXCrematic | on 3 Removal fro | m State crematory | isposition (Name or other place) | M | arch | 20c. Location - C | |
| Baltim permit. Pa Departmen Important injury or | 4 Donation 5 Other S 21. Signature of Funeral Service | | ALTAIL | 22. Name and Ad | natory 1 | 8,2009 avmond 1 | | rnie, MD Service,P.A |
| | 23a. Part I. Enter the disease, of | AX65 | M00641 | 5635Was | shington | Ave., La | a Plata, | ,MD20646 |
| Physician / /Medical | failure. List only one cause | e on each line. | ic (heroin) | | | ic or respiratory arre | est, snock, or neart | Approximate Interval Between Onset and Death |
| xaminer | Immediate Cause (Final diseas or condition resulting in death) | | consequence of): | Income | acton | | F 17 13 | |
| ler . | Sequentially list conditions, if any, leading to immediate | | consequence of): | | | is a l | | |
| ed nsit Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | consequence of): | | | | <u> </u> | |
| = p = | | d | 23a,27,28a-f | norMF | a890 //2 | 3 / N Q Tritt | | |
|), be e- siciar urial | X UNPENDED IF FEMALE: | | utcome of pregnancy | , perme, | g030 4/2 | 3/09 11 | 23d. Date of de | liven |
| Box 68760 e death certificate b the attending physic d for use as the bu hysician//Mee | 23b. Was decedent pregnant in past 12 months? | the 1 Live bi | rth 2 | Fetal death | 3 Ectopic pre | gnancy | Month | Day Year |
| Box te death the atter ted for u | 1 Yes 2 No 9 Ur | | 5 | Other (Specify | ···· | | | |
| , P.O. Erres that the d | Part II. Other significant condi | itions contributing to | death but not resulting in | the underlying ca | use given in Part I. | | | te to the cause of death? Probably 4 V Unknown |
| Records, The law require: ficate has been sig , page 2 should bb | | | | | | 24a. Was a | an 24b. We | re autopsy findings available |
| Che law The law ate has age 2 si | | | | | | autop: perfor 1 ✓ Yes | med? dea | r to completion of cause of th? Yes 2 No |
| of Vital Recing Physician: The Uneral director, page | 25. Was case referred to medical examiner? | al Hospital: | | | Place of Death (Che | ck only one) | | |
| n of Vi ding Physi n. After this funeral dir | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date o | patient 2 ER/Outpa of Injury 28b. Time | | Other Nu | | Residence 6 🗸 | Other: Scene |
| ion tendin death. | | odina. | Day, Year) /13/09 | .0:30 am | Yes 2 X No | unk | | |
| Division of Vital Records, pital or Attending Physician: The law require ours after death. Firted Director: After this certificate has been si filted in by the tuneral director, page 2 should Dertification: To Be Completed | 3 Suicide 6 X Cou | | of Injury - At home, farm, house | street, factory, of | fice building, etc. | 28f. Location (S or Town, St Lothian | | or Rural Route Number, City |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me | | | of my knowledge, death of examination and/or investated | | | | | |
| F 3 F 3 B | 29b. Signature and title of certifi | er | | | icense number | | | (Month, Day, Year) |
| | 30 Name and address of account | tor tor | | COREIL C |).C.M.E. | | March 14, 20 | 0 9 |
| | Name and address of person Margarita Korell MD. | Assistant Med | | 1 Penn Stree | et, Baltimore, M | D 21201 | | |
| State Registrar | 31. Date filed (Month, Day, Year) | nng 3 Reg | gistrar's Signature | well. | | | | |
| DHMH 17 Rev 1/2001 OCME 2006 | MAR & T | LUUJ KKAN | ORIGI | | | OC | ME | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mary L. Yates March 2, 0900 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Lorian Nursing Home Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr. 7, 19 Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Months Days Hours 026-16-3654 83 1925 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 X No **Black** Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker U.S. Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dolan Yates Irene Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred D. Williams/Nephew 7153 Wedmore Ct., Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 3/9/2009 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln F. H. 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumon (or as a consequence of): verpiratory failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 ☐ Other (specify) rlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy sepsis 2 **Z** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician

Physician

/Medical

Examiner

Funeral

Director

1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene.
Heath and Mental Hygiene, tem 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Example traumatic event, the Medical Example or the results of the medical example.

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other or other

Physician

/Medical

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f show the Medical Examinar must be mutilied at

Director

Completed by Funeral

Be

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Examiner

Physician/Medical

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Certification: To

Medical

29a. Certifier (Check only one)

signed by the at be detached f has After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

| 9 □ Unknowň | | |
|-------------------------------------|------------|----------------------------|
| art II. Other significant condition | | not resulting in the under |
| Chronic ver | ral failur | re, ad |
| dementia | , attial | fibrilla |

recurrent 25. Was case referred to medical examiner?

27. Manner of Ceath 5 Pending investigation 1 Natural
2 Accident Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 2 □ No

ar lane #103 Columbia MP 21044

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

Ø

death

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 18, 2009 Year **Physician** 9:05 AMM Helen Young Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick 609 Schley Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. June 4, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕏 F Maryland 95 217-10-0572 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanth or count by notified at ¶∑Yes 2 No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 U.S.A. 609 Schley Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Tes 2 To log If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 1 □Yes XX No White Specify Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Melissa Smith W. Osbie Brown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) partment of Health a cortant: If item 27 is finjury or other trains 300 Park Avenue, Frederick, MD 21701 PR Mrs. Barbara A. Keeney, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c important: If any injury or Mount Olivet Cemetery March 21, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Keeney and Basford PA Funeral Home 21. Signald MO0255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHEONIC OBSTEUCH Pulmoning **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a conse juence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year Dav 5 Other (specify) 9 Unknown 9 Unknown signed by the following signature of the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s eutopsy perform 1 ☐Yes 2 No 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 040307 March 18, 2009 MO Causul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene B. Casagrande, M.D., 1564 Opossumtown Pike, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Sand. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 09326 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 3 **Physician** 50 5:10 PM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside Assisted Living Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 89 Director 233-12-7962 19,1919 Virginia August Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Joseph M. Ayres DOD: 3/19/09 TOD: Baltimore, Maryland 21215-0036 Director 1 ☐Yes 2 No Md. Balto. Parkville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2300 Covered Bridge Garth 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑1Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, Its Magnos. Elementary/Secondary (0-12) College (1-4or 5+) 12 Budget Analyst Amoco Oil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James D. Ayres Frances Bolton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Pollack DTR 2300 Covered Bridge Garth Parkville, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 3-23-2009 Timonium, Md. 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. NOttingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) R **Physician** STAT un knows /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 10 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one)

certificate nours after death.

neral Director: After this certificat
v filled in by the funeral director, ps Hospital or Attending Physician: Division

Certification: To

2 PNO 1 ☐ Yes 27. Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

29b. Signature and little of certifie

5 Pending investigation 6 ☐ Could not be determined

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 \sum Nursing Home 5 \sum Residence 6 \times Other (Specify) \hbare 1 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar's Signature 31. Date filed

and manner stated.

To the Hospital within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 21 2009 **Physician** Andrews /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Balto If Under 1 Year Nursing e swick 9. Birthplace (State or Foreign Social Security Number birthday) **Funeral** Months Days Hours 1 □ M 2 56 F 87 South Carolina Yrs. 213-26-3490 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland a or 28a-f show be notified at 10a. State 10b. County 1 Hes 2 No Baltimore Director Md 10e. Street and Number
1279 Beck 10g. Citizen of What Country? 21040 "natural", or items 23a Completed by Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No Specify: Black 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced er than "natur, the Medical F 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any Injury or other traumatic event, the Medionce. College (1-4or 5+) Elementary/Secondary (0-12) Education ducator 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Andrews William Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐Removal from State Men 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebravascular disease and metry of & broke Years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit certificate be executed and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached fo P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

700 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W to the STREET, BALTMARE, NO 21211

29c. License number

D13657

29d. Date signed (Month, Day, Year)

March 25, 2009

1 - For State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1929 PM NNE SINIA 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, **Funeral** Year) 214-78-8116 1 □ M 2 💢 F Months Days Hours Min. MARYLAND Director MAY 6,1961 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Director BALTIMORE 1 XYes 2 No MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 MARQUETTE U.S.A. 6018 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TAX AND ACCOUNTING BUSINESS SELF EMPLUYED 3 YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHNSON POMPEY IDA MAE ROBERT \mathcal{J} . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) FAWN LANE, RICHMOND, VA 23233 AMBER GREEN (DAUGHTER) 12658 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEM. PARK 03/25/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

TR. FUNERAL HOME 21. Signature of Funeral Service Licenses illiams 2140 N. FULTON AVE, BALTIMURE, MARKLAND &121/ Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final arrhythmia **Physician** Fatal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed melliTus Diabetes sician and burial-trans Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 🗌 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page: Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 054428 3-18-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square DR Balto 1000 FRANKLIN md 21237 B PIPKIN DR Michael State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20

09328

| 09-02337 | |
|--------------|--|
| Robert Brown | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 09329

| | 1- For State | Certificat | te of Death | Reg. No. | | | |
|--|--|--|---|---|--|--|--|
| Physician/ | Registrar 1. Decedent's Name (First, Middle, L | Last) | 220: 11 | 2. Date of Death Month Day Year 1202 brs | | | |
| ledical Examiner | ROBERT | MELVIKI | BROWN | March 23, 2009 | 1303 hrs | | |
| | 4a. Facility Name (if not institution, | give street and number) | 4b. City, Town, or Location of Deat | h 4c. County of | Death | | |
| | Bon Secours Hospital | | Baltimore | | | | |
| Funeral | Social Security Number 6 | . Sex 7. Age (In yrs. last birtho | | _ | Birthplace (State or Foreign | | |
| Director | | XM 2 F 73 | Yrs. Months Days Hours Mi | MAY 12,1935 | Country) MARY (AND) | | |
| | Usual Residence of Decedent | | | | | | |
| any | 10a. State 10b. County | 10c. City, Town or | r Location | | 10d. Inside City Limits | | |
| * · | MARYIAND WI | 10 BA17 | IMORE | | 1 Yes 2 No | | |
| Maryland 28a-f show d at once | 10e. Street and Number | 0.727 | 10f. Zip Code | 10g. Citizen of Wha | t Country? | | |
| the Maryland a or 28a-f sh tiffed at one | 10e. Street and Number | WEAVE BOOD | 21229 | 1).S.F | 7. | | |
| death with the Maryland or items 23a or 28a-f she must be notified at once Tuneral Director | | HERNE ROAD | 13. Was Decedent of Hispanic Origin? (| Specify Yes or No- 14. Race - | American Indian, Black, | | |
| seath with ritems 23 nust be no | 11. Marital Status 1 Never Married 2 Mar | | If Yes, specify Cuban, Mexican, Puer | | | | |
| orite | Never Married 2 2 Married | 1 X Yes 2 No | 1 Yes 2 No specify: | Specify: | BLACK | | |
| s after | 3 Widowed 4 Divor | ced If Yes, Give Year or Dates: | pecedent's Usual Occupation (Give kind o | | | | |
| 11215-0036 Id be filed within 72 hours after feelal Hygiene narked other than "natural", event, the Medical Examiner | | ,,g | uring most of working life. DO NOT use re | etired) | 1 | | |
| 5-0036 cd within 72 hour lygiene other than "natt he Medical Exau | Elementary/Secondary (0-12) | College (1-4 or 5+) | CLERK | CSX | 1 | | |
| 003 Vithii ene er th | GTH GRADE | | | ne (First, Middle, Maiden Surname) | | | |
| 15-003 filed within 1 Hygiene of other th i, the Med | | .ast) | all mod | V RA | OOKS | | |
| 21215-0036 hould be filed within 77 hould be filed within 77 hd Mental Hygiene is marked other than tite event, the Medical To Be Compile | YERNON | DKULE 119h | . Mailing Address (Street and Number o | r Rural Route Number, City or Town | , State, Zip Code) | | |
| ID 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 77 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Re Committee thy Funeral Director | | F (13F-1) | | AVE, BALTIM | | | |
| nore, MD 2 ages 1 and 2 shou nt of Health and N :: If item 27 is n other traumatic | CHET BROW | | f Disposition (Name of cemetery, | Date 20c. Location - | City or Town, State | | |
| or He of Her tr | 20a. Method of Disposition 1 | 3 Removal from State cremato | ory or other place) | 1- 1-10 - 100 | muse MONICIA | | |
| imo Page nent c | 4 Donation 5 Other Spe | (1 100) | | 3/30/2009 DISINGS | | | |
| Baltimore, permit Pages I a Department of He Important: If ite | 21. Signature of Funeral Service L | icensee | 22. Name and Address of Facility | ON JR. FUNERI | AL HOME | | |
| a 50 5 5 | Withis | M. Williams | | | | | |
| Physician | 23a. Part I. Enter the disease, or of failure. List only one cause of | complications that caused the death. Do no | t enter the mode of dying, such as cardial | or respiratory artest, shock, or flea | Between Onset and | | |
| Medical | Immediate Cause (Final disease | a. hypertensive athe | erosclerotic cardio | vascular disease | Death | | |
| xaminer | or condition resulting in death) | Due to (or as a consequence of): | | | | | |
| | Sequentially list conditions, | b | | | | | |
| | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a consequence of): c. | | | | | |
| 1137 | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | | | | |
| nd ransit | | d | | | | | |
| 760, icate be executed physician and the burial - transit | X UNPENDED IF FEMALE: | X AMENDED #23a,27,pe | rME, G890 4/6/09 T1 1 per ME G890 4/14/ | 09 TT | | | |
| 760, icate be physic the bur | IF FEMALE: | 23c. If yes, outcome of pregnancy | | 200. 2000 01 | | | |
| ritificating p | | | Fetal death 3 Ectopic pre | gnancy Month | Day Year | | |
| Box 68 e death certif the attending | past 12 months? 1 Yes 2 No 9 Unk | Pregnant at time of death | Other (Specify) | | | | |
| Records, P.O. Box 68. The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | > < | ions contributing to death but not resulting | g in the underlying cause given in Part I. | 23e. Did tobacco use contr | ibute to the cause of death? | | |
| that the detacl | Part II. Other significant conditi | bils continuiting to death but not reconting | g II tilo anasily ii g sassa g | 1 Yes 2 No 3 | Probably 4 V Unknown | | |
| S, F | | | | | Were autopsy findings available | | |
| ords v required shoul | | | | autopsy | orior to completion of cause of death? | | |
| ecc he lav te ha | ompleted — | | | | ✓ Yes 2 No | | |
| | 25. Was case referred to medica | | 26.Place of Death (Che | eck only one) | | | |
| /ita | m examiner? | Hospital: 1 Inpatient 2 ✔ ER/O | Outpatient 3 DOA Other: Nu | rsing Home 5 Residence 6 | Other: | | |
| of \ g Phy frer tl neral | 27 Manner of Death | 28a. Date of Injury (Month, Day, Year) 28b. | Time of Injury 28c. Injury at Work? | 28d. Describe how injury occur | red | | |
| n din | 1 X Natural 5 Pend | ding | 1 Yes 2 No | | | | |
| isic | 2 Accident Investigation 1 Suicide 6 Coul | 28e. Place of Injury - At home, f | arm, street, factory, office building, etc. | 28f. Location (Street and Numb or Town, State) | er or Rural Route Number, City | | |
| Div Is after it all or Is after it is afte | | rmined (Specify) | | or rown, state) | | | |
| I hou the | 29a. Certifier 1 Certifying P | hysician: To the best of my knowledge, de | eath occurred at the time, date and place, | and due to the cause(s) and manne | r as stated. | | |
| Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b | (Check only one) 2 Medical Example 29b. Signature and title of certifier | miner:On the basis of examination and/or | investigation, in my opinion, death occurr | ed at the time, date and place, and | due to the cause(s) | | |
| 5 with 5 con | 29b. Signature and title of certific | and manner stated. | 29c. License number | 29d. Date sign | ned (Month, Day, Year) | | |
| | [[M]] | -1mo | O.C.M.E. | March 24, | 2009 | | |
| | 20. Name and address of name | who completed cause of death (Item 23a) | | | | | |
| 79 | Donna M. Vincenti, M | | r 111 Penn Street, Baltimore | , MD 21201 | | | |
| Sta | 31 Date filed (Month, Day, Year) | Tool not be Connection | | | | | |
| Regist | MADOS | 1009 Jener B. | parkel | | | | |
| DHMH 17 Rev 1/20 | 001 | | RIGINAL | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charles William Bittorie Sr. March 19:53 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 3 194 **Funeral** 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Months Days Hours 219-38-1010 68 Director 1941 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Carroll Director Sykesville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2159 Cimaron Place 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1959-1 √ Yes 2 ☐ If A es, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐Yes 2√ No Specify: þ Specify: white 3 Widowed 4 Divorced 1963 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, Ite Magnee. Elementary/Secondary (0-12) 12 College (1-4or 5+) transportation truck driver 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Frank Bittorie Frances Theresa Kramerage 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Bittorie (spouse) 2159 Cimaron Place, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State All County Cremation 3-25-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic moplasm of sinknewn primary months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ff any, leading to min said cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examir that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a ☐Yes 2☐No 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed Dulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a, Was an autopsy performed? Yes 2 \(\square\) No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) REJ 000 Juna M.D March, 20, 2009

State Registrar 31. Date filed (Month, Day, Year)

Jeura Sanderp M.D. Schai Hospitalof Baltimore 2401 W Belvidere Arinue, Baltimore 1717 - 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

| | | | For State of Maryland State of Maryland Registrar | | rtment of He | | | eg. No 2 0 0 0 | 00331 | |
|-------------------------------|--|----------------------|--|-----------------------|---|--|---|--|--|--|
| ı | Physicia | an | 1. Decedent's Name (First, Middle, Last) James Russell Barlow | | | | 2. Date of Deat Month March | Day Year 2009 | 4:18a M | |
| 1 | /Medic Examin Funeral Director | er | 4a. Facility Name (If not institution, give street and number) Carroll Lutheran Village 5. Social Security Number 257-36-4752 Carroll Lutheran Village 6. Sex 1 X M 2 F 90 | t birthday) . Yrs. | 4b. City, Town, or L Westmins If Under 1 Year Months Days | ter If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec 3 1 | Day, Year) Country) | | |
| | ъ | tor | Usual Residence of Decedent 10a. State 10b. County 10c. City, 7 | own or Loc | | | Dec 3 | | 0d. Inside City Limits | |
| | 3a or 28s | Funeral Director | 10e. Street and Number 17 Middle Grove Court East | | 10f. Zip Code 21157 | | | 0g. Citizen of What Coun JSA | itry? | |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a fledical Examination to other traumatic event, if a fledical Examination of the montal and once. | | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No WWII | 1 | Mas Decedent of His fYes, specity Cuban I □Yes 2∭XNo | Specify: | | 14. Race - Americ Black, White, e Specify: whi | etc. | |
| altimore, Maryland 21215-0036 | d within 72 ho giene. er than "natur tre Medical | Completed by | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 | | dent's Usual Occupat kind of work done du DO NOT use retired) ice techni | .cian | | NCR | Justry | |
| and | ild be filed fental Hy rked othe iic event, | To Be C | 17. Father's Name (First, Middle, Last) James Barlow | | | 18. Mother's Name | e (First, Middle, M maidei | Maiden Surname) n name Wyatt | - | |
| Mary | and 2 shouealth and No 27 is maiser traumai | | 19a. Informant's Name/Relationship (Type. Print) Bev Leasure (daughter) | | | | st, Wes | r, City or Town, State, Zip tminster, MI | 21157 | |
| imore, | . Pages 1 a Iment of Hea tant: If item jury or othe | | 1 M Burial 2 L ICremation 3 L I Hemoval from State 1 | llawn | sition (Name of natory or other place Cemetery | 3-30 | -09 | Baltimore, N | MD | |
| Balt | permit. F Departm Importal any injul | | 21. Signature of Funeral Service Licensee Pougl Hought Substitution | P | .O. Box 19 | 95 Sykesv | ille, M | | Cnapel | |
| 98260, 大 | Physician //Medical Examiner published step physician and step physici | al Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on lact the death. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C | nce of): | e Pri | ota | 66 | aner | Interval Between Onset and Death | |
| O. Box (| death certi e attending d for use a | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea | eath 3 | ☐ Ectopic pregnancy ☐ Other (specify) | | | 23d. Date of deliv Month | ery Day Year | |
| ds, P. | uires that I n signed by Id be deta | by | Part II. Other significant conditions contributing to death but not result | ng in the u | nderlying cause give | n in Part I. | 23e. Did to 1 □ Y | bacco use contribute to t es 2 No 3 ☐ Prof | he cause of death? bably 4 Unknown | |
| Vital Records, | ician: The law requires that the certificate has been signed by the ector, page 2 should be detache | Completed | 25. Was case referred to redical | | | 26. Place of Deat | 1,0100 | med? death? 2 No 1 □ Yes | ppsy findings available impletion of cause of | |
| Division of Vit | ending Phys sath. or: After this he funeral dir | Certification: To Be | examiner? 1 Yes Hospital: 1 Inpatient 2 E | 8b. Time o Injury | f 28c. Injury Work M 1 □ Y | r: Nursing Ho | ome 5 Resid 28d. Describe h | ence 6 ☐ Other (Speci ow injury occurred | | |
| נו | pital Durs a eral I | Medical Ce | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated. | ledge, deat | th occurred at the tim nvestigation, in my op | ne, date and place binion, death occu | , and due to the orred at the time, or | cause(s) and manner as date and place, and due t | stated. to the cause(s) | |
| Y | To the Hos within 24 hd To the Fun completely | Med | 29b. Signature and title of certifier | | 29c. License | number 0 5 5 8 | 45 | 29d. Date signed (Month, | | |
| | | | 30. Name and address of person who completed cause of death (Item 2 | 205 | Print) i | KING | SPR | ww. I | 2009 | |
| | St Regist | ate rar | 31. Date filed (Month, Day, Year) AR 2 5 2009 | par | Kad | / | | | | |

| | | - | For State of State of Registrar | Maryland | | irtment of H <i>tificate of L</i> | | | iene eg.No. 🥎 | 000 | 00221 |
|--|--|-------------------|--|--|--------------------------------|---|--|---|------------------------------------|--|---|
| 1 | Physicia | an | 1. Decedent's Name (First, Middle, Last) | 1 | | | | 2. Date of Death | Day | Year | 3. Time of Death |
| | /Medic | al | Katherine Irene Ba 4a. Facility Name (If not institution, give street and num. | | | 4b. City, Town, or | Location of Death | March | 19, 20 | y of Death | 2:35pm M |
| - | Examin | er | 37 Monacacy Circle | 2 / | | Taneyt | | | C | arrol | 1 |
| | Funeral Director | | | 7. Age (In yrs. la | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, June 22 | Year) , 1953 | 9. Birthp Cour V | place (State or Foreign htry) A |
| | put 🛦 | | Usual Residence of Decedent 10a, State 10b, County | 10c. City | , Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| | Maryla f sho | tor | MD Carroll | , , , | , | | eytown | | | | 1 □ Yes 2 No |
| | r 28a- | Director | 10e. Street and Number | | | 10f. Zip Code | | 11 | 0g. Citizen of | | ntry? |
| | th with | | 37 Monacacy Circle | | | 21787 | | | U | SA | |
| 336 | permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mentall Hydiene. Important: If tiem Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the finalism Examination in militied at once. | by Funeral | 11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced 12. Was Decected Armed Ford 1 ↑ Yes, Give Year or Dail | œs? 2 X No e | | Was Decedent of Hi fYes, specify Cuba I∐Yes 2 X ☐ No | spanic Origin? (Sp n, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | Bla | ice - Americ ack, White, fy: Whi | etc. |
| 715-00 | in 72 hou. s. in "natura Medical E | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1- | 4or 5+) | (Give | dent's Usual Occupa kind of work done of DO NOT use retired | luring most of work | | 16b. Kind of E | Business/In | dustry |
| 717 | d with | Som | O College (1- | 401 517 | Non | е | | | None | | |
| Iland | uld be file Mental Hy Irked oth | To Be (| 17. Father's Name (First, Middle, Last) Edgar Francis Baughan | | | | 18. Mother's Name Grace | Goode Goode | Maiden Surna | me) | |
| , Mar) | ind 2 shorell and 1 st | . 3 | 19a. Informant's Name/Relationship (Type. Print) (Pa Mr. & Mrs. Edgar Baughan | rents) | 1 | ng Address (Street a Oak Hill | | | | | o Code) |
| altimore, Maryland 21215-0036 | Pages 1 a nent of He ant: If item ury or othe | | 20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify) | tate C | emetery, cřen | sition (Name of natory or other plac Mem. Par | e) | | ^{20c.} Location Sykesv | • | |
| Balt | permit. Departi Imports any inj | | 21. Signature of Funeral Service Licensee | 40076 | 4 A | AIGHT FUN O Box 195 | EKAL HOMI Sykesvi | E & CHAP Lle, MD | EL P 21784 | . A . | |
| 4 | riflicate be executed /Medical Examiner as the burial-transit | al Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | or as a consequence as a consequence or a consequence or a conseque | uence of): uence of): | LIN | PARCT | 101 | | | |
| O. Box 687 | death cei e attendir d for use | Physician/Medical | | irth 2 Fetal ant at time of d | Idéath 3[| ☐ Ectopic pregnance | 1 | | | ate of deliv | ery Day Year |
| ds, P. | law requires that the as been signed by th 2 should be detache | by | Part II. Other significant conditions contributing to de | ath but not resu | ulting in the u | nderlying cause give | en in Part I. | | | | he cause of death? bably 4 🗹 Unknown |
| <u> </u> | The ate h page | Completed | 25. Was case referred to medical | | | | | | med? 2 Wo | | opsy findings available ompletion of cause of |
| SIND Signature of the second o | | | | | | | | | in Assisted | | |
| É | al or Atte s after det il Directo ed in by th | Sertific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildir | of Injury - At hong, etc. (Specif | ome, farm, str | eet, factory, office | | 28f. Location (Si City or Town | treet and Nun n, State) | nber o r Run | al Route Number, |
| 1 | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical (| 29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner; On the based and mann | asis of examina | wledge, deat tion and/or in | th occurred at the tine tine tine tine tine tine the tine tine to the tine | me, date and place pinion, death occu | , and due to the c rred at the time, d | ause(s) and late and place | manner as e, and due t | stated. to the cause(s) |
| | To the withing the complete co | Ž | 29b. Signature and title of certifier | olinh | 10 | D Z | e number - 49 4 2 | _ 2 | 9d. Date sign | red (Month, | Day, Year) |
| | | | 30. Name and address of person who completed calls | e of death (Item | n 23a) (Type, | Print) 50 95 M | arshalo | e Dr. | Elkno | lge | MD 21075 |
| ř. | Sta Regist | | 31. Date filed (Month, Day, Year) NAR 2.5 2000 | egistrar's Signa | ture | del . | - 1 | | | 0 | |

State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:15 PMM March 22, 2009 Nancy Blake Barbosa /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🗷 F 85 10/04/1923 NY Director 035-20-3861 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r than "natural", or items 23a or 28a-f show the Medical Examination at be notified at 1 □Yes 2 MNo Director Wheaton MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with TISA 20906-Funeral 12622 Epping Way 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caucasian Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Education Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Educator is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ed bluods Clarissa Parsons Holland Charles Raymond Blake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12622 Epping Way Wheaton, MD 20906-Health a Paul Barbosa/Son permit. Pages 1 and Department of Heali Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Mar 25 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Chesapeake Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rapp Funeral & Cremation Services Tyle Dohmus 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arolio RIVEN GURL **Physician** /Medical Due to (or as a consequence of): Examiner Stag if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۾ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? /es 2 No certificate 2 No 1 ☐ Yes 1 □Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 24 hours after death.

Funeral Director: After this etely filled in by the funeral dir 28b. Time of 28d. Describe how injury occurred 27. Manyler of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 65485 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1500 For

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BORNSTEIN. 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CARE MONITGOMERY MANOR POTOMAC Potomac 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

MA 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/03/1913 5. Social Security Number **Funeral** 1 M 2 F Months Days Hours Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notifled at 1 ☐ Yes 2 No Director Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20886-Funeral 19155 Roman Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. s filed within 72 hours after de Il Hygiene. other than "natural", or Item Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Caucasian \$ 3 Midowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Newspaper Elementary/Secondary (0-12) College (1-4or 5+) Executive Editor 12 should be filed with and Mental Hygier 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Phillips ၉ Harry Bornstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a ant: If Item 27 is P.O. Box 1158 Rockville, MD 20849-Marje Perry/Daughter Injury or other Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mar 25 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State permit. Page Department Important: If any Injury or Chesapeake Crematory Beltsville, Maryland 4 Donation 5 Dother (Specify) 2009 21. Signature of Pureral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADVANCED DEMENTIA **Physician** /Medical Due to (or as a consequence of): FAILURE
Due to (or as a consequence of): Examiner THRIVE Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed attending physician and for use as the burial-transit ADVANCE, D Due to (or as a consequence of): Box 68760. Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Day 5 ☐ Other (specify) signed by the at d be detached for P.O. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00057458 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6502 KENILWORTH AVE #100 RIVERDALE MD SINGH

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 5 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18^{Day} Month MARCH 2009 Year **Physician** 3:20 PM TOMMY LEE BLAND /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 6414 CABIN BRANCH COURT CAPITOL HEIGHTS 8. Date of Birth (Month, Day, Ye MARCH 26 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1 K M 2 □ F 1931 VIRGINIA 77 Director 234-44-8249 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f sho 1√2 Yes 2 □ No Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 USA 6414 CABIN BRANCH COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2K Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) marked other than College (1-4or 5+) Hygiene. PRIVATE GREYHOUND TICKER SELLER permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MADGE GARNER MARION BLAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6414 CABIN BRANCH COURT CAPITOL HEIGHTS, MARYLAND TOMMY E. BLAND/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State RIVERDALE CREMATORY: 3/24/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility J. B. JERKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 C Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò cate has been signification of the category. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate I 1 ☐ Yes 2 ☑ No 2 ⊠No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1⊟ res 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,

completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sol er 3001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

| ames A Bullock | Please 7 | Cype or Print in Bl | | | | | gible. | |
|--|---|---|-----------------------|--|-------------------------------|---------------------------|-------------------------------------|---|
| ines A Bullock | 1- For State | State of Maryland | - | ent of Health al ate of Death | na Mental H | ygiene | 20 | 09 0933 |
| Discolation | Registrar | Aiddo Last) | Certinica | tile of Death | | 2. Date of Deat | eg. No. | |
| Physiciaı Iedical Examin | | A • | | Bullo | ak | Month March 20. | Dav Year | 3. Time of Death 2140 hrs |
| | oanco | itution, give street and number) | | | or Location of Death | | 4c. County of Dea | |
| | 4923 Edgemere A | | ' | Baltimore | | | | • |
| Funeral | 5. Social Security Number | 6. Sex 7. Ag | e (In yrs. last birth | iday) If Under 1 Ye | ar If Under 24Hrs | . 8. Date of Bir | l th(MM/DD/YYYY) 9. E | Birthplace (State or |
| Director | 231-22-162 | 5 1 _X M 2 F | 79 | Yrs. Months Da | ys Hours Min. | ⊸ | Fore | |
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| any | 10a. State 10b. Cou | inty | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| end show nce. | MD | NA | Ba. | ltimore | | | | 1 X Yes 2 No |
| daryland 28a-f show 1 at once. | 10e. Street and Number | | <u> </u> | 10f. Zip Code | | 10 | 0g. Citizen of What Co | untry? |
| th the M 23a or 2 notified | 5 4923 Edgeme | ere Ave | | 21 | 215 | | U.S.A. | |
| ms 23 | 11. Marital Status | 12. Was Decedent | | 13. Was Decedent of H | Ispanic Origin? (Sp | | - 14. Race - Ame | erican Indian, Black, |
| death or ite | 1 Never Married 2 | Married Armed Forces 2 | No No | If Yes, specify Cuba | an, Mexican, Puerto | Rican, etc.) | White, etc. | |
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| 5-0036 Iled within 72 Hygiene. I other than the Medical | Elementary/Secondary (0 12th grade 17. Father's Name (First, Min | | | HIEDOCOM | Y 18.Mother's Name | /First Middle N | | pebr. |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | Nathaniel | | | | | | , | |
| D 2121 should be fi and Mental 7 is marked natic event, | 19a. Informant's Name/Relat | | 19b | . Mailing Address (Stre | Lillie eet and Number or F | HOWard Rural Route Num | d ber, City or Town, Sta | te, Zip Code) |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sher traumatic event, the Medical Examiner must be notified at once | Lillie Bull | lock-Daughte | | 438 Shirl | | | | |
| Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, | 20a. Method of Disposition | | 20b. Place o | Disposition (Name of c | | Date | 20c. Location - City | |
| Baltimore, ormit. Pages I an Department of Han Important: If iter | 1 X Burial 2 Crem 4 Donation 5 Othe | ation 3 Removal from St | aic | son Fores | t Vot 3 | /30/00 | Owings | Mills, Md |
| Baltin permit. J Departm Importa | Signature of Funeral Ser | | Parti | 22. Name and Addre | ss of Facility | 30/03 | OWINGS | MIIIS/ MG |
| E.E.S. | Humis | B. Mete | | 4300 Wab | ash Ave, | Balti | imore, Mo | 21215 |
| Physician | 23a. Part I. Enter the disease failure. Let only one ca | e, or complications that caused ause on each line. | the death. Do not | enter the mode of dying | g, such as cardiac o | r respiratory arre | est, shock, or heart | Approximate Interval Between Onset and |
| /Medical xaminer | Immediate Cause (Final dise | | osis of | Liver | | | | Death |
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| | Sequentially list conditions, if any, leading to immediate | Due to (or as a cons | equence of): | | | | | |
| | cause. Enter Underlying Ca | eo | | | | | | 2.0 |
| ed nsit | if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death) L | | equence of): | | | | | |
| | X UNPENDED | d. | 27 per | me g891 5- | 1_00 *** | | | |
| | IF FEMALE: | | | ше доэт 5- | 1-09 VL | | lood Bata of data | |
| cax 68760, eath certificate be a strending physicis for use as the buri | 23b. Was decedent pregnant past 12 months? | in the 23c. If yes, outcor | ne of pregnancy | Fetal death 3 | Ectopic pregna | incy | 23d. Date of delive Month | Day Year |
| Box 6 death cer he attend ed for use | 5 Past 12 Mo 9 Past 12 No 9 Past 12 | Halmann I - | time of death 5 | Other (Specify) | | | | |
| be der | IF FEMALE: 23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9 Part II. Other significant co | 9Oriknown | h h | | 1 1 10 11 | 00 - Dista | | |
| | a l'art il. Other significant co | notions contributing to dead | ir but not resulting | in the underlying cause | given in Part I. | | bacco use contribute t 2 ✓ No 3 Pr | |
| ords, l | g | | | | | 24a. Was a | | autopsy findings available |
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| | | | | | | 1 🗸 Yes | | |
| Vital ysician: his certif | 25. Was case referred to me examiner? | Hospital: | | | Other Nursin | | | |
| 그 등 기 등 등 | 1 Yes 2 No 27. Manner of Death | 28a. Date of Inju | | tpatient 3 DOA ime of Injury 28c. Inj | ury at Work? | | Residence 6 Oth | er: Scene |
| n of ading Ph. | 1 T Noticed | (Month, Day,Y | (ear) | | Yes 2 No | 200. Describe i | low injury occurred | |
| Division all or Attendii sts after death. all Director: A led in by the fu | 2 Accident | nvestigation 28e Place of In | iurv - At home, far | m, street, factory, office | | 28f Location (S | Street and Number or F | Rural Route Number, City |
| Division Spital or Att | Suicide 6 6 | Could not be determined (Specify) | ,, | ,,, , | bonding, oto | or Town, Si | | toral reduce Hamber, Only |
| | | g Physician: To the best of m | v knowledge, dea | h occurred at the time. | date and place, and | due to the cause | e(s) and manner as sta | ated. |
| To the Hos within 24 h To the Fun | | Examiner:On the basis of exam | | | | | | |
| y = 3 = 8 : | 29b. Signature and title of ce | and manner stated. | | 29c. Licen | se number | | 29d. Date signed (M | onth, Day, Year) |
| | Montain | Mr. While | | O.C | .M.E. | | March 21, 2009 | |
| | 30. Name and address of per | rson who completed cause of d | leath (Item 23a) | <u> </u> | | | 1 | |
| 1 | Margarita Korell MI | D. Assistant Medical | Examiner | 111 Penn Street, E | Baltimore, MD 2 | 21201 | | |
| Sta | a 31. Date filed (Month, Day, Ye | ear) 32. Registra | r's Signature | | | | | |

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Idik Diooks | | I- For State | of Maryland | | | or Health ar of Death | io Menta | i Hygiene | | 20 | 09 0933 |
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| Physicia | | Registrar 1. Decedent's Name (First, Middle,La: | st) | | mouto | - Dodin | | 2. Date of D | | | 3. Time of Death |
| Medical Examin | | F | RANK CROU | CH BRO | OOKS | | | Month March 2 | 22, 200 | 9 Year | 1536 hrs |
| | | 4a. Facility Name (if not institution, give | ve street and number) | | | 4b. City, Town, o | r Location of D | Death | 4 | c. County of De | _ |
| | | Sinai Hospital 5. Social Security Number 6. S | T- A- | . (1 1- | - 4 1-1-45 - d 3 | Baltimore | - 1611-46 | Miles 10 Date of | Dieth (100 | | /A |
| Funeral Director | | 146-18-7388 1 | M 2 F | e (in yrs. ia: | st birthday) / | If Under 1 Ye Months Da | | Min. June | | 1 | Birthplace (State or reign Country) Maryland |
| any | H | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Loc | eation | | | | | 10d. Inside City Limits |
| * . | | Maryland N/A | | | F | Baltimore | City | | | | 1 X Yes 2 No |
| faryland 28a-f show 1 at once. | Director | 10e. Street and Number | <u> </u> | | - | 10f. Zip Code | crey | | 10g. Cit | tizen of What Co | ountry? |
| th the M 23a or 2 notified | | 8 Bellemore Ro | ad | | | 212 | 10 | | | USA | |
| hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 X Married | 12. Was Decedent Armed Forces? 1 X Yes 2 | | | | | | | | |
| after (| DY F | 3 Widowed 4 Divorce | If Yes, Give Year or Dates: | | | Yes 2 X N | | | | | White |
| hours 'natur Exam | | 15. Decedent's Education (Specify of | | | | ent's Usual Occupa most of working lif | | | 16b. | Kind of Busines | ss/Industry |
| , MD 21215-0036 and 2 should be filed within 72 hours at ealth and Mental Hygiene. ten 27 is marked other than "natural traunnatic event, the Medical Examin | ompleted | Elementary/Secondary (0-12) | College (1-4 or | D*) | I | President | | | Iı | nsuranc | e Brokerage |
| 15-003 iled withi Hygiene. d other th | 틼 | 17. Father's Name (First, Middle, Las |) | | | | 18.Mother's I | Name (First, Midd | | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than | 8 | Rodney Joseph B | | | 1 | | Mar | | | dgers | |
| MD 2 tid 2 shoul lith and M in 27 is m aumatic | ٩ | 19a. Informant's Name/Relationship (Ellen Schneider B | | lfe) | 4. | ing Address (Streellemore | | | | - | |
| e, MD 2 I and 2 shou Health and I item 27 is r | - | 20a. Method of Disposition | <u> </u> | 20b. P | lace of Disp | osition (Name of co | | Date | | . Location - City | |
| E ~ % E 2 | | 1 X Burial 2 Cremation 3 | | | | other place) 's Cemet | erv | 3/26/200 | 9 Ba | altimor | e, Maryland |
| Baltimore, permit Pages I an Department of Her Important: If ite Important: If ite injury or other tr | 1 | 4 Donation 5 Other Specify 21. Since or a prun specify Mar In D Lawson | | | | | | | | | INC and 21212 |
| Physician | \dashv | 23a. Part I. Enter the disease, or com | | the death. | | | | | | | Approximate Interval |
| /Medical | | failure. List only one cause on e Immediate Cause (Final disease a | ach line. . Hypertensive A' | heroscle | erotic Car | diovascular Di | isease | | | | Between Onset and Death |
| xaminer | | or condition resulting in death) | Due to (or as a cons | | | | | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate | Due to (or as a cons | equence of |): | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | | | | | | | | | |
| ansit and | | events resulting in death) Last | Due to (or as a cons | equence of |). | | | | | | |
| '60, ate be executed physician and he burial - transit | Medical | UNPENDED | AMENDED | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, Hospital or Altending Physician: The law requires that the death certificate be executed 24 hours after death. Fineral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - trans | /Me | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, outcor | ne of pregn | | | | | 23 | 3d. Date of deliv | |
| Box 687 e death certifica the attending p ed for use as th | Physician/ | past 12 months? | 1 Live birth 4 Pregnant at | time of dea | | Fetal death 3 Other (Specify) | Ectopic p | regnancy | | Month | Day Year |
| Boy e death the att | hysi | 1 Yes 2 No 9 Unknow | n g Unknown | | | Outer (aprosity) | | | | | |
| P.O. es that th igned by oe detach | by P | Part II. Other significant conditions | contributing to deat | n but not re | sulting in th | e underlying cause | given in Part | | d tobacco | | to the cause of death? Probably 4 VI Unknown |
| S, Francisco | Ed | | | | | | | | | | autopsy findings available |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be | Completed | | | | | | | au | utopsy erformed? | prior | to completion of cause of |
| Vital Rec ysician: The his certificate | S | | | | | | | 1 🗸 Ye | | No 1 🗸 | |
| ital sician: s certi | Be | 25. Was case referred to medical examiner? | Hospital: | int 2 V | ER/Outpatie | | Othor | heck only one) Nursing Home 5 | Resid | dence 6 Ot | ther: |
| n of Vi | 음 | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of Inju | | 28b. Time of | | ury at Work? | | | njury occurred | |
| ion tendin eath. or: A | 틽 | 1 Natural 5 Pending | | ear) | | 1 | Yes 2 N | 0 | | | |
| Divisi pital or Att ours after de neral Direct filled in by | Certification: | 2 Accident Investigat 3 Suicide 6 Could not | 28e Place of In | jury - At ho | me, farm, st | reet, factory, office | building, etc. | | n (Street n, State) | and Number or | Rural Route Number, City |
| Divis | 핅 | 4 Homicide determine | ed (Specify) | | | | | or row | n, otato) | | |
| D To the Hospital within 24 hours To the Funeral completely filled | Medical | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine | ian: To the best of m r:On the basis of exa and manner stated. | | | | | | | | |
| Faro | ž | 29b. Signature and title of certifier | | | | | nse number | | 29d | . Date signed (i | Month, Day, Year) |
| | | my hu. | m. 5 | 5) | | 0.0 | .M.E. | | Ma | arch 23, 200 | 9 |
| | | 30. Name and address of person who Ling Li, MD Assistant N | completed cause of ca | | | eet, Baltimore | MD 2120 | 1 | | | |
| Sta | ate | • | / | r's Signatu | 4 / | and a | | · | | | |
| Registi | rar | 31. Date filed (Month, Day, Year) NAR 2 5 20 | 109 Clever | NA | 1. 14 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10b, perFH, G889, 3/25/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death OFFTEN BOWINS MORT CLOSY 7 **Physician** MILDRED 200 /Medical WYC 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTMOKE JEWISH CONV. HUMLE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2 F Months Days Hours 049-20-2013 02 1906 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ä BALTIMORE 1 ZYes 2 No a or 28a-f shot be notified a MI Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number TERRACE 2304 POPLAR U5.4 21207 "natural", or items 23a Examiner must by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACLE Baltimore, Maryland 21215-0036 3. Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) FREDERICK COUNTY and Mental Hygiene. Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) TEACHER SCITOOL SYSTEM 4 XRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be find Mental I BRUNCR JEANNERE C. OFFUT W JOHN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grund POPLAR TEARACE permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other trai GOWANS MD, clay. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State FATRVION (cm. FREDERICK 4 ☐ Donation 5 ☐ Other (Specify) ROLLINS FIN. Item & 22. Name and Address of Facility CARY 21. Signature of Funeral Service Licenses REPLEKE MP 21701 new d. Rollis 55 Approximate
Interval Between
Onset and Death
On Coll 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 K 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 00 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 🗌 Yes 27. Manner of Death 1 Matural 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After I 5 ☐ Pending investigation (Month, Day Year) within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 4 4 8 17 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier pleted cause of death (Item 23a) (Type, Brint) Belwelere are Selhirose Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 5 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #23b & 26 Per State of Maryland Department of Health and Mental Hygiene amend Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Vivian Marie Beers 16, March 2009 4:44 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 629 Flintlock Drive Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In vrs. last hirthday) **Funeral** Months Days Hours 1 □ M 28 P 220-18-7964 83 Director 28, 1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow d other than "natural", or items 23a or 28a-f shovevent, the Wedford Evention in ust be notified at 1 ☐ Yes 2 ☑ No Director PA Airville York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7481 Woodbine Road death v by Funeral 17302 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event and once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Walton Dufour <u>Lillian Christina Bearch</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Taylor/ Daughter 629 Flintlock Drive, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1⊠ Burial 2 □ Cremettion 2 □ R 4 □ Denation 5 □ Other (Specify) Removal from State Bel Air Memorial Gdn: 3-19-09 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Sign ture of Funera 50 W. Broadway, Bel Air, MD 21014 23a/Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician facture to Three disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Depression Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy this certificate has been signed by the atteral director, page 2 should be detached for Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \ No 2 D110 1 □Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home - Sensidence of Mother (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 | Yes 2 | No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Much 17 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAV. D 615 Bel Air, MD 21014 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAR 2 5 2009

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last)
Harvey L. 2. Date of Death 3. Time of Death Barnes Year Physician 12:15 AM March 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Season's Hospice Randallstown If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1⊠M 2□ F 57 1/5/1952 578-66-4942 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Widow Examinar your be notified at 1 Yes 2 No Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 USA 501 North Franklin Street Funeral 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 □Yes 2 □X0o Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Government Print 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shop Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Dupree Howard Barnes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5914 L Street, Capitol Heights, MD 20743 item 27 Michelle Hamilton / Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/24/2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service Licenson Dorota Marshall Men Sho M Po Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE RENAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to intra-clat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner certificate be executed burial-transi Exami INTRAVENCUS DRUG ABUSE

Due to (or as a consequence of): and physician s the burial Box 68760 Physician/Medical as ding asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant atten for us The law requires that the death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 **Ø**No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) NUS 105 PICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H45931 March 19th 7009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 SMITHAVENUE SVIKE ZOS Baltimore MD 21209 egistrar's Signature 31. Date filed (M State

DHMH 17 Rev 1/2001

Registrar

25 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🛭 🤇 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PETER COLANGELO 7:15 A.M MARCH 21. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE STELLA MARIS HOSPICE TIMONIUM If Under 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 XM 2 ☐ F Director 220-09-4499 87 11/20/1921 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show perr it. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dep-rtment of Health and Mer tal Hygelen. Dep-rtment of Health and Mer tal Hygelen "Inatural", or items 23a or 28a-f show Important: If the 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The "wides Experience" and by rufflind at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1845 DARRICH DRIVE 21234 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🟋 No Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) SHEET METAL MECHANIC HEVRON 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (ဂ္ DOMINIC COLANGELO JOSEPHINE MISTRETTA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1845 DARRICH DRIVE BALTIMORE, MD 21234 ELLEN COLANGELO/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, DULANEY VALLEY MEM. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/24/2009 COCKEYSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUENRAL HOME, P.A. 21. Signature of Funeral/Servic Licensee M01139 Jac 00101 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Yea 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 🗆 Yes 2 🗌 No 2 Accident filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examiner Nurse Practition Pagner stated.

State Registrar

PETER COLANGELO

29b. Signature and title of certifier

31. Date filed (Month, Day,

Dorother Maholland RSM CRNF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

DOROTHEA MAHOLLAND, RSM CRNP

2300 DULANEY VALLEY RD.

146961

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2009 Mary Elizabeth Capley March 23 7:55 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air 2120 Northridge Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖾 F Months Days May 22, Director 82 1926 Maryland 219-22-2950 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experience rulal by natified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 USA 2120 Northridge Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent EV Armed Forces? 1 □ Yes 2 ★No If Yes, Give Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Newspaper 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Adam Fink ဥ Mildred (nmn) Spurrier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 2120 Northridge Drive, Bel Air, MD 21015 James R. Capley / Son permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 4 ☐ Donation 5 ☐ Other (Specify) 3-27-09 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home 50 W. Broadway, Bel of Funeral Servi Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 2 240 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred

P.O. of Vital Records,

al or Attending F Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospital

State Registrar

31. Date filed (Month, Day, Year, MAR 2 5 2009

29b. Signature and title of certifier

Natural

3 Suicide

29a. Certifier

Medical

2 Accident

4 Homicide

(Check only one)

5 Pending investigation

6 ☐ Could not be

MAZUTSTHA

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

00058775

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea **Physician** 1:40 AM Marc 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltima If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Funeral Year) Months Days Hours Min 1 ☐ M 2 🖫 F 216-24-8603 Director Mary land Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No by Funeral Director 1 M.oce 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ NeverMarried 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify Specify: Rac 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 000 MOU nthia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Horest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gura Howe Balto M) Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 6/6 Uascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Severa attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Many of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ∏No 2 Accident 24 hours after deat b Funeral Director: Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2. and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0064788 C 20 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person RMA Year) Registrar's Signature 31. Date filed (Month, Day, State Registrar

ORIGINAL

Delores Renee Dewitt Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 09 09344 1. For State Certificate of Death Registrar . 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Time of Death Medical Examiner Month Day March 16, 2009 0438 hrs RENEE DEWITT DELORES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 11113 Webb Wood Court Upper Marlboro Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex If Under 1 Year | If Under 24Hrs **Funeral** 7. Age (In vrs. last birthday) oreign MARYLAND Director Days Hours 251-33-4403 $_{2}$ X $_{F}$ М 9/8/1967 Usual Residence of Decedent 10a. State IDc. City, Town or Location 10d. Inside City Limits PRINCE GEORGE'S 28a-f show LARGO 1 XYes 2 No MD notified at once, Director 10e. Street and Number : 10f. Zip Code 10g. Citizen of What Country? 20774 9704 CEDAR HOLLOW LANE USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14: Race - American Indian, Black, or items must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married White, etc. Yes Widowed f Yes. Give Yea Divorced Yes 2 X No specify: Specify: BLACK à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036 Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. event, the Medical 4 NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT SMITH ROSA DEWITT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is ABIMBOLA OGUNFOWOKAN/HUSBAND 14661 LONDON LANE BOWIE, MARYLAND Baltimore, I permit. Pages 1 and Department of Healt 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 mportants 3/19/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY Donation 5 Other Specify 21. Signatur uneral Ser License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions; Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that finitiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a,27,28a-f,permE, g889 3/31/09 TT X UNPENDED physician Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 X Unknown Unknown Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other, DOA Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 2 1 Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Yes $2X_{N_0}$ subject assaulted -Pending Fd 3/16/09 Fd 4:38 am 2 Accident Investigation

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, p Division of Vital

Medical 29b. Signature and title of certifier Oluo. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day Year)

State Registra

DHMH 17 Rev 1/2001

OCMF 2006

Suicide

X Homicide

29a. Certifier 1

Could not be

determined

and manner stated

111 Penn Street, Baltimore, MD 21201 32. Registrar's

28e. Place of Injury - At home, farm, street, factory, office building, etc

in vehicle

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

28f. Location (Street and Number of Rural Route Number, City or Town, State) 11113 Webb Wood Ct

March 16, 2009

29d. Date signed (Month, Day, Year)

Upper Marlboro, MD

Ebony Renee Dewitt UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 09345

| | | - For State | , | Certificate o | f Death | | Reg | . No. | |
|---|----------------|---|--|-------------------------|----------------------|-------------------|-------------------------|--------------------------------------|--|
| Physicia | _ | Decedent's Name (First, Middle, | Last) | | | | Date of Death Month | Эау Үеаг | 3. Time of Death |
| edical Examir | | EBONY I | RENEE DEW | ITT | | | March 16, 2 | .009 | 0438 hrs |
| and | | 4a. Facility Name (if not institution, | | | 4b. City, Town, or | | ith | 4c. County of Dea | |
| | | 11113 Webb Wood Co | urt | _ | Upper Marlt | ooro | | Prince Georg | |
| Funeral | | 5. Social Security Number 6 | S. Sex 7. Age (In | n yrs. last birthday) | If Under 1 Yea | | | (MM/DD/YYYY) 9. B | ion COUTU |
| Director | | 249-77-9626 | 1 M 2 XF 20 | Yrs | Months Days | s Hours M | in. FEB 12 | 1989 | carolina CAROLINA |
| | 444 | Usual Residence of Decedent | | | | | | | CANTILINA |
| any. | | 10a. State 10b. County | 100 | c. City, Town or Loca | tion | • | | | 10d. Inside City Limits |
| · . | _ | MD PRINCE | GEORGE S | LARGO | | | | | 1 X Yes 2 No |
| Aaryland 28a-f show | 용 | 10e. Street and Number | <u>,, , , , , , , , , , , , , , , , , , ,</u> | | 10f. Zip Code | | 100 | . Citizen of What Co | untry? |
| after death with the Maryland al?, or items 23a or 28a-f sho iner must be notified at once | Director | 9704 CEDAR HOL | LLOW LANE | | 20774 | 4 | | USA | |
| ith th | .— L | 11. Marital Status | 12. Was Decedent Eve | | | | Specify Yes or No- | 14. Race - Ame | erican Indian, Black, |
| death wi | Ē | 1 X Never Married 2 Mar | | | Yes, specify Cubar | n, Mexican, Puer | to Rican, etc.) | White, etc. | |
| ter de | F | 3 Widowed 4 Divor | 1 Yes 2 X | NO 1 | Yes 2 X No | specify: | | Specify: BI | LACK |
| urs af | 9 | 15. Decedent's Education (Speci- | or Dates: | | nt's Usual Occupa | | | 16b. Kind of Busines | |
| 136 hin 72 hours a e. than "natural edical Examin | iệ. | Elementary/Secondary (0-12) | College (1-4 or 5+) | during r | nost of working life | . DO NOT use r | etired) | | |
| 36 hin 7 than than | 힏 | 12TH | | MEDI | CAL ASSIS | STANT | | PRIVATE | |
| 21215-0036 uld be filed within 7 Mental Hygiène. marked other than | Completed | 17. Father's Name (First, Middle, L | ast) | | | | me (First, Middle, M | aiden Surname) | ==== : |
| 215 se file tal H ked c | Be (| CRAIG WILSON | | | | DELORE | S DEWITT | | SC4-141-44 |
| AD 21215-0036 2 should be filed within 72 hours h and Mental Hygique. 27 is marked other than "natur | 0 | 19a. Informant's Name/Relationsh | p (Type, Print) | 19b. Mailir | ng Address (Stree | et and Number of | or Rural Route Numb | er, City or Town, Sta | ite, Zip Code) |
| MD d 2 sho ith and 1 27 is | | ABIMBOLA OGUNF | OWOKAN/STEP-F | ATHER 14 | 661 LONDO | ON LANE | BOWIE M | | 20715 |
| 2 2 5 | | 20a. Method of Disposition | | 20b. Place of Dispo | | metery, | Date | 20c. Location - City | or Town, State |
| ages at of the left | | | 3 Removal from State | RIVERDAL | ' ' | ORV 3 | /19/2009 | RIVERDALI | E, MARYLAND |
| Baltimore, permit. Pages I a Department of He Important: If ite | - | 4 Donation 5 Other Special Saprice | | | Name and Address | | | NKINS FUNI | |
| Balti permit. Departin Importa | - 1 | | \supset | 1 | 7474 T.AN | DOVER R | | VER, MARYLA | |
| Physician | | 23a. Part I. Enter the disease, or o | | | | | | | Approximate Interval Between Onset and |
| /Medical | | failure. List only one cause of | on each line. a. Asphyxia | | | | | | Death |
| kaminer | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a consequ | ence of): | | | | | |
| S. | | Sequentially list conditions, | b | | | | | | |
| | ē | if any, leading to immediate cause. Enter Underlying Cause | . Due to (or as a consequ | ence of): | | | | | - 1 |
| _ | Examiner | (Disease or injury that initiated | Due to (or as a consequ | ience of). | | | | | |
| ted Insit | ы | events resulting in death) Last | d | | | | | | |
| 760, cate be executed physician and he burial - transit | edical | X UNPENDED | AMENDED 23a, | ,27 , 28a-f, | perME, G | 889 3/3 | 1/09 TT | | |
| .760, ficate be a physicia the buria | ed | IF FEMALE: | 23c. If yes, outcome | of pregnancy | | | | 23d. Date of deliv | erv |
| | - I | 23b. Was decedent pregnant in the | | - | etal death 3 | Ectopic pre | gnancy | Month | Day Year |
| Sox 687 feath certifing e attending for use as t | Physician | past 12 months? | 4 Pregnant at tim | | Other (Specify) | | | | |
| Box e death c the atten | λ | 1 Yes 2 No 9 X Unki | nown 9 Unknown | | | | | | <u> </u> |
| that the d | | Part II. Other significant condition | ons contributing to death be | ut not resulting in the | underlying cause | given in Part I. | | | to the cause of death? |
| , P.O ires that t signed by | d by | | | | | | 1 Yes | 2 No 3 P | robably 4 🗹 Unknown |
| of Vital Records, rg Physician: The law requir wher this certificate has been s meral director, page 2 should t | Completed | | | | | | 24a. Was a autops | | autopsy findings available o completion of cause of |
| e law e has ge 2 s | g E | | | | | | perform 1 ✓ Yes 2 | med? death | |
| tal Rec | | 25. Was case referred to medical | | | 26.Plac | e of Death (Che | | | 100 2 110 |
| Vital I ysician: his certifi director, | Be | examiner? | Hospital: 1 Inpatient | 2 ER/Outpatie | | Othor | | Residence 6 V Ot | her: Scene |
| 1 of Virting Physic | 은 | 1 Yes 2 No 27. Manner of Death | 128a. Date of Injury | 28b. Time of | | ury at Work? | 28d. Describe h | ow injury occurred | |
| anding | 딍 | 1 Natural 5 Pendi | (Month, Day, Year | | 12 am 1 | Yes 2 X No | subject | assaulte | d |
| isior Attend or death. rector: by the | cat | 2 Accident Inves | tigation 28e. Place of Injur | v - At home, farm, str | eet, factory, office | building, etc. | 28f. Location (S | treet and Number or, | Rural Route Number City |
| Division spital or Attendi hours after death. meral Director: / | Certification: | Tt deter | mined (Specify) | in vehicle | 2 | | or Town, St | _{ate)} IIII3 W [arlboro, | ebb wood Ct MD |
| El e on | | 29a. Certifier | ysician: To the best of my k | nowledge death occ | urred at the time. o | date and place. | | | |
| To the Hos within 24 h To the Fur completely | edical | (Check only one) 2 ✓ Medical Exam | niner: On the basis of examin | nation and/or investig | ation, in my opinio | on, death occurre | ed at the time, date a | and place, and due to | the cause(s) |
| To To com | Med | 29b. Signature and title of certifie | and manner stated. | | | ise number | | 29d. Date signed (/ | |
| | - | CMMAT. | 7 | | 0.0 | .M.E. | | March 16, 200 | 9 |
| | | 20 None and address | who completed on the state of | th (Itom 22c) | | | | | |
| | | 30. Name and address of person Ana Rubio MD. Ass | who completed cause of dea istant Me <u>d</u> ical Examir | | Street, Baltim | ore, MD 212 | 201 | | |
| | | | | ×- | Prob | | | | |
| St | tate | 31. Date fin ARt 25, 200 | B Character S | A. And | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Joseph Jesse Davis, III March 21, 2009 8:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7659 East Arbory Court George Laurel Prince If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F 54 212-68-2344 14, 1954 Director New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Exar liver must be notified at Director 1 XYes 2 No MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7659 East Arbory Court 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 Divorced "natural", traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Supervisor Retail Store h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Jesse Davis, Jr. Vernestine Carmon ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 Is
any Injury or other trau 8807 Boulder Hill Place, Laurel, MD 20723 Vernestine C. Davis /mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery | Mar 26, 09 | Laurel, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiomyopathy years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): 68760. Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy õ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, should be Completed by Diabetes, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 2 🛛 No 1 ☐ Yes 1 ☐ Yes of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 XNatural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24997 March 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Dr, #103, Laurel, Maryland 20707 Luis A. Casas, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State parked Registrar

DHMH 17 Rev 1/2001

MAR 2 5 2009

DHMH 17 Rev 1/2001

State

Registrar

Joseph Reilly,

31. Date filed (Month, Day, Year)

MD,

MAR 2 5 2009

32. Registrar's Signature

3418 Old Olandwood Court, Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | State of Ma | | artment of Fi rtificate of L | ieaith and Mei Death | | . No. 2009 | 09348 |
|-------------------|--|----------------|---|---|--|--|--|--|---|--|
| | Physicia | an | 1. Decedent's Name (First, Middle | Last) | F | Lynn | 2. | Date of Death Month | Day 2 Year | 3. Time of Death |
| 4 | /Medic Examin | al | 4a. Facility Name (If not institution, | give street and number) | V | 4b. City, Town, or | Location of Death | VIOIC V | 4c. County of Deal | |
| 4 | LAdillisi | -8 | The Johns Hopkins | Hospital | • | Baltimore | | | | |
| | Funeral Director | | 548-64-8530 | 6. Sex 7. Agr | e (In yrs. last birthday) 64 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. 8. Hours Min. | Date of Birth (Month, Day, Ye 03/09/ | ear) Co | thplace (State or Foreign untry) many |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| | Mary a-f sh fied a | ctor | MD Anne | Arundel | Crownsvi | lle | | | | 1 ☐ Yes 2 🗷 No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip-Code | | 10g | . Citizen of What Co | ountry? |
| | ath wi | | 374 Kyle Road | - Los III - B | - : iii | 21032 | inneria Odnina (Consit | | JSA 14. Race - Ame | vican Indian |
| 36 | within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent If Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates: | Vo | If Yes, specify Cuba | ispanic Origin? (Specify an, Mexican, Puerto Rica Specify: | an, etc.) | Black, Whit | |
| 9 | 2 houral | | 15. Decedent | 's Education | 16a. Dece | edent's Usual Occup | pation during most of working | 16 | 6b. Kind of Business | |
| 21215-0036 | be filed within 72 ho tral Hygiene. ed other than "natur event, the Medical | Completed | (Specify only highes Elementary/Secondary (0-12) | College (1-4 or 5 | +) life. | DO NOT use retired | () | 1 | Military | |
| | filed Hygi ther int, ti | Be C | 17. Father's Name (First, Middle, L | | | | 18. Mother's Name (F | First, Middle, Ma | aiden Surname) | |
| Maryland | | P P | James Edward Fl | ynn | | | Elsie Ariz | zona Unk | nown | |
| lary | and and is m | 1 | 19a. Informant's Name/Relationsh | | I | | and Number or Rural R | | | Zip Code) |
| | rt 2 # d | | Susan Flynn/Wife | e | 20b. Place of Disp | | d Crownsvil | | 21032 oc. Location - City or | Town State |
| Baltimore, | Pages nent of ant: If it | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) | pecify) | cemetery, cre | ematory or other place ake Crema | tory Inc. 2 | ar 24 | Beltsville | |
| Balt | permit. Pag Department Important: I any injury o | J. J | 21. Signature of Funeral Service L | icensee R | 1443 | | and Funeral | | | aryland 21286- |
| | | | 23a. Part 1. Enter the disease, or shock, or heart failure. List of | complications that caused | the death. Do not er | nter the mode of dyir | ng, such as cardiac or r | espiratory arres | it, | Approximate Interval Between |
| 1 | Physician | X D | Immediate Cause (Final disease or condition | | te Reno | a Fail | uve | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as | a consequence of): | | 13/15/5-2 - 5: | | | |
| | | er | Sequentially list conditions, | b. Ker | 201 DI | sease | | | | |
| | ted nsit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | , | | | | | |
| | ficate be executed physician and as the burial-transit | | resulting in death) Last | Due to (or as | a consequence of): | | | | | |
| 58760, | te be ysicia he bur | ledical | | d | | | | | | |
| _ | rtifica ng ph e as tl | | IF FEMALE: | | | 270 | | | | |
| D. Box | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | ysician/N | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown | 2 Fetal death 3 | ☐ Ectopic pregnanc ☐ Other (specify) | | | 23d. Date of de Month | Day Year |
| s, P.O. | s that the | by Phys | Part II. Other significant condition | ns contributing to death b | out not resulting in the | underlying cause gi | iven in Part I. | | | to the cause of death? |
| ğ | w requires that been signed to should be de | ted | | | _ | | | 1 \(\text{Yes} | | |
| of Vital Records, | The law re ate has be page 2 sh | Completed | | | | | | 24a. Was an autopsy performe | prior to | utopsy findings available completion of cause of S |
| /ita | | Be (| 25. Was case referred to medical examiner? | Hospital: 😽 | | Oth | 26. Place of Death C | | | |
| d | Physician: this certifica eral director, | မ | 1 ☐ Yes 2 D No 27. Mapner of Death | 28a. Date of Inju | | ent 3 🗆 DOA | 4 L Nursing Home | | ce 6 Other (Spe | ecify) |
| | Jing P. After t funer | tion: | Natural 5 Pendin | g (Month, Da) | | Worl | | 3. Describe non | injury occurred | |
| Division | or Attendatter deatl | Certification: | 3 Suicide 6 Could determ | not be 28e Place of ini | ury - At home, farm, s c. (Specify) | treet, factory, office | 28f | Location (Street, City or Town, | eet and Number or F State) | Rural Route Number, |
| _ | To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di | edical Ce | 29a. Certifier 1 Certifyln (check only one) 2 Medical | g Physician: To the best of Examiner: On the basis of end manner st | f examination and/or | th occurred at the time timestigation, in my convertigation, in my convertigation. | me, date and place, and ppinion, death occurred | d due to the car I at the time, da | use(s) and manner a te and place, and di | as stated. ue to the cause(s) |
| | To the To the comple | Med | 29b. Signature and title of certifier | | | 29c. Licenso | e number | 290 | d. Date signed (Mon | th, Day, Year) |
| | | | Hrescelle | a Nelso | n | KE: | 000-0 | | rouch | 20,2009 |
| 1 | | | | ELSON | | | 600 No | orth Wolf | e St, Baltim | ore, MD, 21287 |
| | Sta Regist | | 31. Date filed (Month, Day, Year) MAR 25 200 | | ar's Signature | 2 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 18, Day 2009 Year **Physician** 3:30 a. M Meininger Garrett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | March 3, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Year) 1941 Nebraska 1 □ M 2 🕏 F 68 577-54-6853 **Director** Usual Residence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, it at Medical Experience must be a cutting at 1√ Yes 2 No Director MT Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 749 Tiffany Drive 20878 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔼 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify ð 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government (Unknown) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madge Madeline Burgee Department of Health and Meni Important: If item 27 is marked any Injury or other traumatic Paul Meininger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 749 Tiffany Drive Gaithersburg, MD 20878 Daniel W. Garrett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 21. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 2009 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Services M00982 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Non-small Cell Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Tyes 2 X No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square M$ Other (Specify) Hospice1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this nours after death.
neral Director: After this
filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28h. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier (X) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Koucetchou, MS D0063748 March 19, 2009 Jocet

Registrar DHMH 17 Rev 1/2001

State

JOCELYNE

P.O. Box 68760.

Division of Vital Records,

201 E UNIVERSITY BUD BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOLLATCHOU MD

32. Registrar's Signature

| | | | For State Registrar | State of Marylar | | artment of F | | | iene | 09 09350 |
|----------------------------|--|-------------------------------|--|---|----------------------------------|---|---|--|-----------------------------|--|
| | Physic /Medi Examii | cal | 1. Decedent's Name (First, Middle, La | n E. (| Gris | 35 4b. City, Town, or | Location of Death | 2. Date of Deat | Day 9, 2 4c. County | Year 3. Time of Death /S3 pm of Death |
| | Funeral Director | | 5. Social Security Number 6. S 217–26–5759 Usual Residence of Decedent | 7 Age (In yrs. | . last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 12 11 | Year) 29 | 9. Birthplace (State or Foreign Country) MD |
| | ne Maryland 8a-f show | ector | 10a. State 10b. County MD Baltin | | ity, Town or Lo | ndallst | own | | | 10d. Inside City Limits 1 □Yes 2 [X]No |
| | with th | I Dir | 10e. Street and Number 3943 Nemo Road | | | 10f. Zip Code | 133 | 11 | 0g. Citizen of V | · |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Evantine must be notified at | Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec | 12. Was Decedent Ever in U Armed Forces? 1 Myes 2 No If Yes, Give Year or Dates: | | Was Decedent of Hi fYes, specify Cuba I □Yes 2 No | spanic Origin? (Sp n, Mexican, Puerto Specify: | | 14. Race Blac Specify | DIGCK |
| 215 | thin 72 e. an "na Matik | plet | (Specify only highest gra | College (1-4or 5+) | (Give | kind of work done d DO NOT use retired, | uring most of work | ring | | siness/Industry |
| 121 | ould be filed within Mental Hygiene. arked other than " atic event, the Mark | Co | 7th grade | na | | Mechani | | | | nployed |
| and | should be fi ind Mental F i marked ot umatic ever | To Be | 17. Father's Name (First, Middle, Last) William Henry | | | , | | e (First, Middle, M th Hunt | laiden Surnam | e) |
| Maryland | 2 shou and M is mar sumat | - | 19a. Informant's Name/Relationship (| Type. Print) | | g Address (Street a | and Number or Ru | ral Route Number, | | |
| | 1 and 2 Health em 27 i | | Margaret Griggs | | _l | | | | | 1d 21133 |
| nor | Pages 1 and nent of Heart of Heart of Heart of Heart of Heart of Heart of h | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1) | Hemovar morn state | | sition (Name of natory or other place | i | | | City or Town, State |
| Baltimore, | permit. Pages Department of Important: If It any Injury or conce. | | 21. Signature of Feneral Service Licen | Gai | M a | Forest Name and Addres rch F/H OO Wabas | s of Facility West | | 115.5 | s Mills, Md 4d 21215 |
| | Physician /Medical Examiner physician and physician and the pnrial-transit | cal Examiner | 23a- Fart 1. Enter the disease, or companies, hock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) | uence of): uence of): rd, o | r the mode of dying R Fib R He Myspa | g, such as cardiac rills, ti ct co to to to to to to to to | or respiratory arre | st, | Approximate Interval Between Onset and Death |
| Box 6 | death certifi e attending p d for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown | 23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d | ıl death 3 □ | Ectopic pregnancy Other (specify) | | | 23d. Date Mor | e of delivery hth Day Year |
| ords, P. | The law requires that the diate has been signed by the cage 2 should be detached | by | Part II. Other significant conditions of | ontributing to death but not resu | ulting in the un | derlying cause give | n in Part I. | | acco use contri | bute to the cause of death? |
| Division of Vital Records, | n: The faw ra ificate has be or, page 2 shu | Completed | OF Was again referred to modified | | | | | 24a. Was an autopsy perform 1 □ Yes 2 | ed2 de | Vere autopsy findings available rior to completion of cause of eath? □ Yes ② □ No |
| <u> </u> | ysicia is cert directo | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Inpatient 2 | ER/Outpatient | Otho | ,, | n <i>(Check only one</i> me 5 ☐ Resider | | V |
| 0 1 | ng Ph kiter th uneral | D: L | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury Work? | | 28d. Describe how | | |
| Divisio | To the hospital or Attending Physician: The hospital constitutions after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag | Certification: To | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At ho building, etc. (Specify | ome, farm, stre | M 1 □Y | es 2□No | 28f. Location (Stre City or Town, | eet and Numbe State) | r or Rural Route Number, |
| : | Hospita 24 hours Funeral etely filled | | Check only 2 Medical Exam | ysicien: To the best of my kno- iner: On the basis of examina | wledge, death tion and/or inv | occurred at the time | e, date and place, inion, death occur | and due to the ca | use(s) and mar | oner as stated. |
| | of the Hospital within 24 hours To the Funeral completely filled | Medical | 29b. Signature and true of ceyffier | and manner stated. | | 29c. License | | | | (Month, Day, Year) |
| 1 | | | 30. Name and address of person who c | J. July wars | 12/49 | | -thue | st b | Pospin | 22 |
| | Sta Registra | .~ | 31. Date filed (Month, Day, Year) | 32. Registrar's Signat | ture | | | | | |

Physician /Medical Examiner that the death certificate be executed

If Item

Department of H
Important: If Itel
any Injury or otl
once.

Physician

/Medical

Examiner

Funeral

Director

t be notified at

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traumatic event, the Medical Examiner

Maryland

Baltimore,

Director

Funeral

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Completed

burial-tran the by page 2 certificate

P.0.

Records,

Division or Vital

Hospital or Attending

the the

Physician/Medical Completed Be ို Certification: After . Funeral Director: stely filled in by the hours

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and Atle of certifier

(Check only one)

5601 LOCH RAVEN BLVD. MAMEDOU

and manner stated.

MAR 2 5 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARIATE

ం

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 212129 12:30PM Lewis Charles Harris, II /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore lowson Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 → M 2 □ F 214-86-9252 39 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinant has notified at 1 XYes 2 No Director MD N/A Baltimore the 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 839 N. Fulton Ave Apt 3 21217 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any or other traumatic excess. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 X No African American \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L.C. Harris Mattie Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mattie Harris/Mother 839 N. Fulton Ave Apt 3 Baltimore, MD 21217 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore, MD 03-25-2009 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Fuperal Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC NON SMALL CELL LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed death? certificate 2 **X**No 1 ☐Yes 2 No 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 📉 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-elta MO D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 JOGINDER F. M. D. OSLER DRIVE TOWSON. MARYLAND MEHTA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAK Z D ZUU9 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:22 AM M 24, 2009 Audrey B. Hamlett March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Joseph Richey Hospice House, Inc. n/a Baltimore 8. Date of Birth (Month, Day, Year) 8/12/1913 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🔀 F 95 223-22-8866 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar aust by multiped at 1 XYes 2 ☐ No Director n/a Baltimore 10a. Citizen of What Country? 10f. Zip Code 10e Street and Number 632 Brisbane Road 21229 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify White Specify. ģ 3 ₩ Widowed 4 □ Divorced Maryland 21215-00 Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Retail Sales 8 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be and Mental Wilse Flowers Salley Devers traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Health Timothy S. Hamlett / Grandson 1803 Abelia Road, Fallston, Maryland 21047 Baltimóre, Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Bonation 5 Other (Specify) Elkridge, Maryland Meadowridge Mem. Pk. 3/28/2009 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Epperal Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician YEARS LONGESTIVE disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner 11 and burial-tra physician Physician/Medical the as attending plant for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) the 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s performed certificate 1 □Yes 2 □No 1 □ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 atural 5 Pending investigation 1 □Yes 2 □No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatine and title of certi DO026327 3-24 30. Name and address of person who complete AMPFIRE, COLUMBIAMD 21045 State Registrar

09-02240 Karen Hall Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 09354

| | | | - For State | | Certif | icate of i | Death | | | Reg | . No. | |
|---------------------------------|---|----------------|---|--|--------------------------------------|-----------------------------------|--|---------------------------|---------------|----------------------------|-------------------------------------|--|
| | Physicia | | Registrar 1. Decedent's Name (First, Midd | le,Last) | | | | 1.563 | | e of Death | | 3. Time of Death |
| Medica | al Examir | | Karen | | | На | 11 | | Moi Mai | nth" rch 19, 2 | Day Year 2009 | 2207 hrs |
| | | | 4a. Facility Name (if not institution 32 Comet Court | n, give street and num | per) | 46 | City, Town, or L | ocation of | | | 4c. County of Baltimore | |
| | | | 5. Social Security Number | 6. Sex 7 | Age (In yrs. last | hirthday) | If Under 1 Year | If Under | 24Hrs 8 D | ate of Birth | (MM/DD/XXXX) | Birthplace (State or Foreign |
| | Funeral Director | 1 | 214 - 96 - 3338 | 1 M 2 X F | 41 | Yrs. | Months Days | Hours | Min. 12 | | | Country) MD |
| | | | Usual Residence of Decedent | | | | | | | | | |
| | any | | 10a. State 10b. County | | , , , , , , | wn or Locatio | | | | | | 10d. Inside City Limits |
| 0 | show sce | 5 | MD Bal | timore | | Parkv | ille | | | | | 1 Yes 2X No |
| 6 | Maryland 28a-f show any d at once | 뒳 | 10e. Street and Number | | | | 10f. Zip Code | | | 100 | g. Citizen of Wha | , i |
| lo | he M | Director | 32 Comet Ct. | | | 1 | 21 | 234 | | | U.S | . A . |
| 13 | death with the Maryland or items 23a or 28a-f sho must be notified at once. | | 11. Marital Status | 12. Was Dece | lent Ever in U.S. | | Decedent of Hisp | | | | | - American Indian, Black, |
| | item ust b | Funeral | 1 Never Married 2 X M | Armed Ford | ces? 2 X No | If Ye | s, specify Cuban, | Mexican, I | Puerto Rican, | etc.) | White, | |
| | fter d | | 3 Widowed 4 Div | vorced If Yes, Give Year | Z X NO | 1 \ | Yes 🗶 No | specify: | | | Specify: | Black |
| | urs a itura amin | 함 | 15. Decedent's Education (Spe | ecify only highest grade | completed) 16 | | s Usual Occupation | | | ne | 16b. Kind of Bus | |
| | 72 ho | 황 | Elementary/Secondary (0-12) | College (1-4 | or 5+) | auring mo | st of working life. I | DO NOT U | ise retired) | | Baltim | ore City |
| 21215-0036 | uld be filed within 7. Mental Hygiene marked other than c event, the Medical | Completed | 12th grade | na | | $T \in$ | eacher | | | | School | System |
| 2-0 | ed w lygie othe | 3 | 17. Father's Name (First, Middle | , Last) | | | | | | | aiden Surname) | |
| 21 | be fill right land land land land land land land land | 8 | Walker J. Sm | | | | | | 1 H. | | | |
| 21 | nould id Me is ma tic ev | ဥ | 19a. Informant's Name/Relations | | | | | | | | | n, State, Zip Code) |
| MD | d 2 sł lth ar n 27 | | Purnell Hall | <u>-Husband</u> | | | | | | | | Id 21206 City or Town, State |
| ē, | Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene nut: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once | | 20a. Method of Disposition 1 Burial 2 Crematio | n 3 Removal from | | ce of Disposit matory or othe | ion (Name of cem er place) | ietery, | Date | , | 20c. Location - | City or Town, State |
| 9 | Page ment o fant: or oth | | 4 Donation 5 Other S | | | | lemoria | | /25/0 | 9 | Arbutu | ıs, Md |
| Baltimore, | pernit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If iten 27 is marked other thinjury or other traumatic event, the Med | 1 | 21. Signature of Funeral Service | | / | 22. Na M D 2 | me and Address | of Facility | + | | | |
| 00 | ₹ 5 T E | 1 | Xala 1 | Varia | | 1430 | 10 Waha | gh A | Ve. F | alti | more, | Md 21215 |
| | hysician | | 23a. Part I. Enter the disease, o failure. List only one cause | on each line. | | | | | | ratory arre | st, shock, or hea | rt Approximate Interval Between Onset and |
| | Medical caminer | 13 | Immediate Cause (Final disease | 1 + 1 - 2 - 2 | slceroti | c card | iovascul | ar d | isease | | | Death |
| | tammer | | or condition resulting in death) | Due to (or as a c | onsequence of): | | | | | | | |
| | | _ | Sequentially list conditions, | b. Due to (or on a | onsequence of): | | | • | | _ | | |
| | | Examiner | if any, leading to immediate cause. Enter Underlying Cause | | onsequence or). | | | | | | | |
| | = | xal | (Disease or injury that initiated events resulting in death) Last | Due to (or as a c | onsequence of): | | | | | | | |
| | ficate be executed g physician and the burial - transit | జ | | d | 20 07 | MT | -001 E/1 | 7. 700 | ידידי | | | |
| | se exe | /Medical | X UNPENDED | AMENDED | 23a,27,p | erme, | go91 3/1 | 4/09 | 11 | | | |
| 260 | ffcate be ig physicia s the buria | 18 | IF FEMALE: 23b. Was decedent pregnant in t | le a | itcome of pregnai | | | | | | 23d. Date of | |
| .89 | | | past 12 months? | Live Dir | th nt at time of death | 2 Feta | | Ectopic | pregnancy | | Month | Day Year |
| Box 68760, | eath e atter for u | Physicia | 1 Yes 2 No 9 🗸 Ur | 7 | | 5 Oth | er (Specify) | | | | | |
| | | 문 | Part II. Other significant condi | tions contributing to | death but not resu | ulting in the ur | nderlying cause gi | iven in Pa | rt I. | 23e. Did tol | pacco use contri | bute to the cause of death? |
| Э. | The law requires that the death certicate has been signed by the attendingage 2 should be detached for use as | ð | | | | | | | | 1 Yes | 2 No 3 | Probably 4 🗸 Unknown |
| ds. | equire een si ould b | Completed | | | | | | | | 24a. Was a | | Vere autopsy findings available |
| Ö | law rahas b | 힐 | | | | | _ | | | autops perform | | rior to completion of cause of eath? |
| Rec | | 흥 | | | | | | | 1 | ✓ Yes 2 | 2 No 1 | Yes 2 No |
| <u> </u> | ysician: The lav his certificate ha director, page 2 | Be | 25. Was case referred to medic examiner? | Ulasaitali | | | - 1 | of Death (Other | (Check only o | | | 4 014 0 |
| Ē | ing Physician: The law requi After this certificate has been uneral director, page 2 should | ၉ | 1 Yes 2 No 27. Manner of Death | | | R/Outpatient 8b. Time of In | | y at Work | Nursing Hor | | Residence 6 v | |
| 0 | ding l Afte funer | ä | 1 V Notural | 28a. Date o (Month, | Day,Year) | .ob. Time of it | | es 2 | ı | Describe ii | ow injury occurre | su |
| <u> </u> | Attendi death. ector: , | aţ | 0 10 | estigation | | | - | | | anation (C | tract and Number | ar Bural Bauta Number City |
| Division of Vital Records, P.O. | lor / after Dire | Certification: | | ald not be | of Injury - At hom | ie, tarm, stree | t, factory, office bi | ullaing, eu | | or Town, St | | er or Rural Route Number, City |
| | spita hours mera y fille | | 4 Homicide | (0) 00)/ | | | | | | | (-) | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director. | ical | (Check only Certifying F | Physician: To the best aminer: On the basis of | of my knowledge examination and | , death occurr /or investigati | ed at the time, da on, in my opinion, | ite and pia , death oc | curred at the | o tne cause ime, date a | e(s) and manner and place, and d | ue to the cause(s) |
| | To T To C | Medical | 29b. Signature and title of certif | and manner sta | ated. | | 29c. License | | | | | ed (Month, Day, Year) |
| | | _ | Mad | 1. C1 - | × not | | O.C.N | M.E. | | | March 20, 2 | 2009 |
| | , | | WWW. | n who completed to | of death /ltom or | 33/ | | | | | | |
| 4 | | | 30. Name and address of person Russell Alexander M | | e of death (Item 2) edical Examir | | Penn Street, | Baltimo | re, MD 21 | 201 | | |
| | C | ate | 31. Date filed (Month, Day, Year | 1 | istrar's Signature | | | | | | | |
| | St Regist | | MAP 25 | | white of. | par | to and | | | | | |

| | | - | Please T | ype or Print in AMEND TTEM#1 State of Maryla 8 per fh g8 | Black Indeli 9a perFH, nd Departir 90 4-10-0 | ble Ink. Ensure A G889,3/25/09,6 Jent of Health and Sate of Death | Mental Hygier | e Legible. |
|----------------------------|--|-------------------|--|--|---|---|--|--|
| | Physicia /Medic | an | 1. Decedent's Name (First, Middle, Last) LOVA FMN | iJ | الـــــ | | 2. Date of Death | Day Year 8.55 A M |
| | Examin Funeral Director | er | 5. Social Security Number 6. Sex 220 - 28 - 4065 | YURSING H | omc f s. last birthday) If U | City, Town, or Location of Deat CLOCK nder 1 Year If Under 24 Hrs ths Days Hours Min | 8. Date of Birth | C. County of Death C. D. L. C. K. 9. Birthplace (State or Foreign |
| | the Maryland | | Usual Residence of Decedent 10a. State 10b. County FRED BL 10e. Street and Number | | City, Town or Location | | 100 | 10d. Inside City Limits 1 □ Yes 2 □ No Citizen of What Country? |
| 36 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Mcdforl Exertinat must be notified at | eral Di | 1603 Colon | 2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give | J.S. 13. Was D | 21702 ecedent of Hispanic Origin? (s specify Cuban, Mexican, Puer ss 2210 Specify: | | 14. Race - American Indian, Black, White, etc. |
| 21215-0036 | and 2 should be filed within 72 hours after dea leath and Mental Hygiene. m 27 is marked other than "natural", or items her traumatic event, Its Medical Experiment. | Completed b | 15. Decedent's Educ (Specify only highest grade | Year or Dates: ation completed) College (1-4or 5+) | 16a. Decedent's (Give kind of life. DO NO | | rking F | Kind of Business/Industry |
| Maryland | should be file ind Mental Hy s marked oth umatic event | To Be (| 17. Father's Name (First, Middle, Last) Rev. Reuben Nic 19a. Informani's Name/Relationship (Tyr. Patricia Gaither | | 19b. Mailing Ado | | me (First, Middle, Maid BROOK'S N ural Route Number, Cit | JICKENS |
| Baltimore, Ma | Pages 1 and 2 anent of Health a surt: If item 27 is any or other tran | | Patricia Galther 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | 20b. | Place of Disposition | (Name of or other place) | Date 20c. | Location - City or Town, State FREDERICK |
| Balti | permit. Pages Department of Important: If ii any injury or once. | | 21. Signature of Funeral Service License Way Color 23a. Part 1. Enter to disease, or compile | leis | 1100 | ULST SDUTT. | st FREDO | FRODERICK LINS FUNEARLINME ELLA MO. Approximate |
| | Physician /Medical Examiner | | shock, or he of failure. List only on Immediate Cause (Final disease or condition resulting in death) | e cause on each line. Due to (or as a conse | emen | Half surface of dying, such as cardia | ic of respiratory arrest, | Interval Between Onset and Death |
| 68760, | eath certificate be executed attending physician and for use as the burial-transit | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or right) that initiated events resulting in death) Last | Due to (or as a conse | | | | |
| O. Box | | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 No 9 □ Unknown | 3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown | tal death 3 ☐ Ecto | pic pregnancy or (specify) | | 23d. Date of delivery Month Day Year |
| cords, P. | w requires that the d s been signed by the should be detached | þ | Part II. Other significant conditions con | • | esulting in the underly | ing cause given in Part I. | | o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available |
| Vital Re | Physician: The law this certificate has traid director, page 2 s | Be Completed | 25. Was case referred to medical examiner? | ospital: | | 0.0 | autopsy performed' 1 □Yes 2 eath (Check only one) | rior to completion of cause of death? No 1 □ Yes 2 □ No |
| of | > .g ₽ | 7: To | 1 Yes 2 No 11 27. Manner of Death | 28a. Date of Injury | ER/Outpatient 3 | DOA 4 Nursing 28c. Injury at Work? | Home 5 ☐ Residence | |
| Division of Vital Records, | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: To | 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Pending investigation 6 Could not be determined | (Month, Day, Year) 28e. Place of Injury - At building, etc. (Spec | Injury M home, farm, street, fa | 1 ☐ Yes 2 ☐ No | 28f. Location (Street City or Town, St. | and Number or Rural Route Number, ate) |
| K | To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by | Medical (| | | | urred at the time, date and place ation, in my opinion, death occ | | e(s) and manner as stated. and place, and due to the cause(s) |
| 79 | To th To th | Me | 29b. Signature and title of certifier | | | 29c. License number | | Date signed (Month, Day, Year) |
| | 14 | | 30. Name and actives of person who co | mpleted cause of death (It | em 23a) (Type, Print) | m00005164 | - Garolan | h mo 4702 |
| | Sta Regist | | 31. Date filed (1871) 2 2009 | 32. Registrar's fig | | 110000 | . 1-000 | |

| | | | For State Registrar | State of Ma | ryland / D | epartment of F Certificate of | lealth and Death | Mental Hy | giene 20 | 09356 |
|---------------------------|--|----------------|--|--|--------------------------|--|--|--|---|--|
| | Physicia /Medic | | 1. Decedent's Name (First, Middle, L Georgia Irene Hu | | 1 | | | 2. Date of De Month | eath _ | 3. Time of Death |
| | Examin | - | 4a. Facility Name (If not institution, g | | | 4b. City, Town, o | r Location of Dea | | 4c. County of | Death |
| | Funeral | | 5. Social Security Number 6. | URS/N (- / Sex 7. Age 1 M 2 M F | Home (In yrs. last birth | Months Days | If Under 24 Hrs | (Month, Da | rth ay, Year) | P. Birthplace (State or Foreign Country) |
| | Director | | 213-01-9904 Usual Residence of Decedent | ILM ZAIL | 90 Y | rs. | | Aug. 1 | 9, 1918 | Nebraska |
| | land ow | | 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits |
| | the Mary 28a-f sh notified | Director | Maryland Harfo | rd | Bel A | 10f. Zip Code | | [| 10g. Citizen of Wh | 1 ☐ Yes 2 No |
| | 3a or | | 101 E. Nichols | Street | | 21014 | | | USA | ·····,· |
| | death | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | ver in U.S. | 13. Was Decedent of In If Yes, specify Cub. | lispanic Origin? (S | Specity Yes or No | | American Indian, |
| 21215-0036 | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It has them 23 or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | | lo | 1 ☐ Yes 🏋 No | | to ricall, etc.) | Specify: | White, etc. White |
| 5-0 | 72 ho 'natur dical | Completed | 15. Decedent's (Specify only highest of | Education grade completed) | 16a. I | Decedent's Usual Occup (Give kind of work done life. DO NOT use retire | ation during most of wo | rking | 16b. Kind of Busi | ness/Industry |
| 121 | vithin ne. han " | ld m | Elementary/Secondary (0-12) | College (1-4or 5- | +) | | d) | J | 0 - 77- | |
| , 12 | filed v Hygie ther t | ပ္ပ | 17. Father's Name (First, Middle, La. | st) | <u></u> | <u>iomemaker</u> | 18. Mother's Na | me (First, Middle | Own Ho | |
| Maryland | should be ind Mental marked o | To Be | William M. Blev | | | | | Leona Cr | . , | |
| ary | 2 shou and M is mar | - | 19a, Informant's Name/Relationship | | | Mailing Address (Street | and Number or F | ural Route Numb | per, City or Town, Si | |
| | and 2 ealth n 27 i | | Raymond W. Huts | on Jr. / So | | 2303 Cullum | · · | | | |
| ore | 0 0 - 5 | | 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 | ☐Removal from State | 1 | Disposition (Name of crematory or other place | - 1 | Date | 20c. Location - C | |
| Baltimore, | | | 4 Donation 5 Other (Special Signature of Funer of Service Lice | | Calvary | Methodist 22. Name and Addre | | | | lle, Maryland |
| Ba | permit. Departr Importa any inje | | Atysler al. | Klugh | | 1317 Cokes | sbury Ro | ad, Abin | gdon, Mar | ome, P.A. Yland 21009 |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that caused ly one cause on each lin | the death. Do n | | ng, such as cardia | c or respiratory a | arrest, | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | _a _ (erehr | valedo | hugus | | | | |
| | Examiner | | | Due to (or as a | consequence o | r): | | | | |
| 10 | | ner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a | a consequence o | 1):1 | | | | |
| W | ecutec and transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | o | | Vty disec | <i></i> | | | |
| 8760, | ate be executed hysician and the burial-transit | | resulting in death) Last | 11 0 | a consequence o | [| | | | |
| 687 | ficate physis the | edical | | d | uvinger | ` | | | | |
| , .ó. Box 6 | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal death | 3 ☐ Ectopic pregnance 5 ☐ Other (specify) _ | у | | 23d. Date Monti | • |
| _ ₽ | w requires that the deben signed by the should be detached | / Ph | Part II. Other significant conditions | contributing to death bu | it not resulting in | the underlying cause giv | en in Part I. | 23e. Did | tobacco use contrib | ute to the cause of death? |
| Z > | quires en sigr uld be | sd by | | | ···· | | | 1 🗆 | Yes 2 □ No 3 | ☐ Probably 4 ☐ hknown |
| テとったら/A Vital Records, | The law re ate has bee page 2 sho | Completed | | | | | | | opsy pri- ormed? de | ere autopsy findings available or to completion of cause of ath? Yes 2 1 No |
| ا ital | iclan: Th certificate ector, pag | BeC | 25. Was case referred to medical examiner? | | | | 26. Place of De | ath (Check only | | 165 2 140 |
| Q S | hysic this ce al direc | ToE | 1 Yes 2 No | | | oatient 3 DOA Oth | 4 Nursing | Home 5 ☐ Res | idence 6 □Other | (Specify) |
| | ding Physicfan: n. After this certific funeral director, | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | | jury Woi | | 28d. Describe | how injury occurred | |
| Soll, | Attend death. sctor; / | icat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not | be 280 Place of initi | rv - At home, far | M 1 □ m, street, factory, office | Yes 2 No | 28f Location | Street and Number | or Rural Route Number, |
| ⊱ O S S | alor As after | Certification: | 4 ☐ Homicide determine | building, etc | (Specify) | , | | | wn, State) | or raid risate realizer, |
| HU | To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune | Medical C | 29a. Certifier 1 Certifying (Check only one) | Physician: To the best of aminer: On the basis of and manner star | examination and | death occurred at the ti l/or investigation, in my | me, date and place opinion, death occ | e, and due to the urred at the time | e cause(s) and mans , date and place, an | ner as stated. d due to the cause(s) |
| 10 | To the within 2 To the comple | Me | 29b. Signature and title of certifier | 100 | | 29c. Licens | e number 14341 | | 29d. Date signed (| Month, Day, Year) |
| | | | 30. Name and address of person who is the state of the st | to completed cause of de | eath (Item 23a) (1 | Type, Print) MD6 | (MV) | 2/1 | 880 | 1 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. egistra | ar's Signatur | hould | | | I | |
| | Registr | - | MAR 25 | 2009 Duen | N B. | garre | | | | |

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Date Month 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** ALONZO ZZZIM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE CHEVRL 405 6-E6R6E 62026E If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Funeral Year) Months Days 1☑ M 2□ F 208-32-2/03 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 20721 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 □ No 1 Never Married 25 Married Specify: BLACK 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 3 Widowed 4 Divorced Ye ar or Dates: "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ital Mone. ENGNEER DODE OF LABOR VI AIN LEANLE 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) FRIEN B 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BREWEWOOd 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service Lie 10220 GUIL FORD Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ardiac Physician /Medical Jue to (or as a consequence of): diabetes Examiner rtension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jue to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans P.O. Box 68760,7 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a d be detached fo 1 □ Yes 2 □ No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy performed? 1 □Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3
Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature appl title of centifier P66592 ho completed cause of death (Item 23a) (Type, Print) 3001 Hospita

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OHNSON URTI 600 O Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death (TH 75 950 7 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Hours 56 21.2-58-6905 6-30-19 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No MD Baltimore Gwynn Oak 10g, Citizen of What Country? 10e. Street and Number 10f Zin Code 5955 Hilltop Avenue 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: specify: African-American 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Administrative Director State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther L. Johnson Jr. Dorain Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Johnson/Wife 5955 Hilltop Avenue, Gwynn OAk, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3-25-09 Woodiawn, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2 NO 1 ☐ Yes 2 \square No 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Funeral Director

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Completed

Be

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Examiner

Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examinar fourt by nother day.

Baltimore, Maryland 21215-0036

and burial-tran attending physiclan for use as the burial signed by I icate has been sig this After after death Director: d in by the 1

Hospital or Attending Physician: The law requires that the death certificate be executed

the

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57 ひし C08 M

CTINOZE NO

State Registrar

31. Date filed (Month, Day, Year) 5

105

30 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#8perFH C889 3/30/09 WS
State of Maryland Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 530 Physician Jacqueline Jones 03-19-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sand Town Furture Care Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **1-946** (Month, Day, **1-946** 02-06-2946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Days Hours 63 219-50-1355 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. The triems 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 X Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 514 Franklin Street 21217 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ☑ No African American <u>\$</u> 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Cleaning Service Abacus 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Travis Mattie Wimberly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11451 Brundydge Drive Osceola, IN 46561 Marvin R. Jones/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 a
Department of He
Important: If item
any Injury or othe Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 03-25-2009 Baltimore, MD Mt. Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a Part1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NEUMONI Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ś 1 MMUNUDEFFICIENCY 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 × Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0059107 M.D

Registrar
DHMH 17 Rev 1/2001

State

BULNESS

82. Registrar's Signature

CENTER DRIVE REISTERSTOWN MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

210

09-02147 Howard Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| oward Jones | | 1- For State Certificate of Death Registrar | Reg. | No. 200 | 9 0936 |
|--|-------------------------------|---|-------------------------------------|--|--|
| Physic Medical Exam | an/ | 1. Decedent's Name (First, Middle,Last) | Date of Death Month Di March 16, 20 | | 3. Time of Death 1815 hrs |
| | | 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 3016 Virginia Avenue Baltimore | | 4c. County of Death | 7 |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 14M 2 F Yrs. Usual Residence of Decedent | | | |
| 15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f show any i, the Medical Examiner must be notified at once. | Completed by Funeral Director | 10a. State 10b. County N/A Baltanov 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No | | | |
| | | 30/6 Virginia Ane 10f. Zip Code 21215 | | Citizen of What Cou | |
| | | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify: | | 14. Race - Amer White, etc. | ican Indian, Black, |
| 2 21215-0036 hould be filed within 72 hours after and Mental Hygiene. is marked other than "matural", after event, the Medical-Examiner. | | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) | | Sb. Kind of Business/ | • |
| y, MD 21215-0036 and 2 should be filed within 7 leath and Mental Hygiens (tem 27 is marked other than traumatic event, the Medica | o Be Corr | 17. Father's Name (First, Middle, Last) Ward E. Jones 18. Mother's Name (Fired) Ce ce | lia | Har | reson |
| nd 2 sealth a | ۲ | | _ Ba | r, City or Town, State Location - City or | 2/2/5 |
| Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti | | 1 Survice 16 see crematory or other place) 4 Donation 5 Other Specify 21. Signy fe of Fun 1 Strvice 16 see 22. Name and Address of Facility 27 | 409 0 | Lans de | rine, mD |
| Medical | | 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellipte. List only one cause on each line. Approximate the Between One Death Street Cardiovas Cular Disease. | | | |
| ⊂,xaminer | | or condition resulting in death) Due to (or as a consequence of): | | | |
| W | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | |
| be executed ician and urial - transit | by Physician/Medical | d. UNPENDED AMENDED | | | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death the Finnerial Directors. After this certificate has been signed by the attending physician and the Pinnerial Directors, whe finnered in which the finnered in which the finnered in the Pinnerial Structure as the burial. Stranding the structure of the burial. | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | , | 23d. Date of deliver Month | y Day Year |
| s, P.O. I | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Clinical history of colon cancer | | cco use contribute to | the cause of death? bably 4 Unknown |
| Division of Vital Records, I ris after dien by visician: The law requires its after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be led in by the funeral director, page 2 should be | Completed | · | 24a. Was an autopsy performe | prior to death? | utopsy findings available completion of cause of |
| ftal Fician: sician: is certifi irector, | Be | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing H | | sidence 6 🗸 Othe | r: Scene |
| ion of Vital Rectending Physician: The Leath for: After this certificate I the funeral director, page | tion: To | 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No | | | |
| Division spital or Attent hours after death neral Director: | Certification: | 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f | f. Location (Stre or Town, State | | ural Route Number, City |
| Di To the Hospital owithin 24 hours a To the Funeral I | Medical | 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | |
| OCME | 2 | 30. Name and address of persons of completed cause of death (Item 2.1a) | N | March 24, 2009 | mur, Day, Fear) |
| Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NAR 2.5 2009 | | | | | |
| Kegis | uell | MAR 2 5 2009 Janua S. Jack | | | |

amend #5&8 Per FH G89155/01/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** RACHELLE JENKINS 2.40 AM 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner LOOD SAMARITAN HODALTAL BALTIMORE NA 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth 1956 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M E Hours MAINE **Director** 107-50-6706 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 No Director Haffinis 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 V No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐Yes 2 No 3 Widowed 4 Divorced n and Mental Hygiene.

Is marked other than "natural" Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 214 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 28-09 neral Sentice Licens 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused it shock, or beart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death CARDIOMYUDATHY **Physician** /Medical Due to (or as a consequence of): Examiner GIMAC LAYOCAMDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 I Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by KENAL FALLUNG 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM 479hs MANCHIT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Actom mo 5601 COLH MAUGO BLUD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 MARCH 19, **Physician** 9:30p M Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 2607½ GARRISON BLVD. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛣 F 1-13-1955 MARYLAND 54 Director 212-74-4425 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE N/AMD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21216 2607 GARRISON BLVD. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 X No fYes, Give 1 Morried 2 Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: BLACK 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) -12-LABORER PACKING -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEATRICE JOHNSON THOMAS CHESTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KATHERINE WALSON (SISTER) 2811 PARKWOOD AVE. BALTIMORE, MARYLAND 21217 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ⊞ Burial 2 □ Cremation 3 Removal from State KING MEMORIAL PARK 3-27-2009 BALTIMORE, MARYLAND 4 Donation 5 DOther (Specify) 21. Signature of Function HIBN R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirting, and the control of t Approximate Interval Between Onset and Death Immediate Cause (Final diseas of condition resulting in death) Physician Due to (or as a consequence f): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dontensu Due to o a a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) sician and burial-trans attending physician for use as the buria Box 68760 Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant ned by the atter 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital : After this certification funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 24 hours after death.

e Funeral Director: A pletely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. To the within 2.

State Registrar

DHMH 17 Rev 1/200

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

arelson M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50W. 32. Registrar's Sig

Hichard

29c, License number

4340 Park Heights Ave Balto.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** March 2:48 a James Edward King Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1810 N. Ashbirton Street Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours IVC. 219-03-6580 Director 2/20/1918 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Evanings must be notified at 1 □Yes 2 □ No Director n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1810 N. Ashburton Street 21216 by Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1V Yes 2 No if Yes, GiveO/2-45 Year or Dates: 2-45 1 Never Married Married Saltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify. Specify: African-American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other that any injury or other traumatic event, I'ms once. Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph King Sr. Emily R. Best ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6553 Eldersberry Court, Elkridge, MD 21075 Sheila Downey/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-30-09 Arbutus, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 1. Signatus of Funeral Service Licensee 9200 LibertyRoad, Randallstown, MD 21133 23a. Part Center the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocandial in fanction **Physician** m, mules /Medical Due to (or as a consequence o): Examiner CHARDIO VASCULIAN DISERSA ATHEROSCUENCOTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 DEMENTIA 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed SUBJECTE + AILURUZ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HYPERTEN STON ALEMIA 2 No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar PARKS HEIGHTS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 2009 4:50 **Physician** Αм Esther Regina Kirk /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 🗓 F WV 217-06-2360 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Extrainer in ust be notified at ury or other traumatic event, It a Medical Extrainer in ust be notified at 1 □Yes 2 No Director Finksburg Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21048 2507 Deer Park Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: WHITE 2 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Ramey Frank Hooe ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trangone. Finksburg, MD 21048 2507 Deer Park Road, (daughter) Judith Pfarr 20b. Place of Disposition (Name of cemetery, crematory or other processing UMC Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-26-2009 Colesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral HOme & Chapel, P.A. PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licensee Robert Freezen 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arlein disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examinel the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (a) as a consequence of): the burial-tran Division of Vital Records, P.O. Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day for 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Be Other: 4 \(\to\) Nursing Home 5 \(\to\) Residence 6 (Specify) Dove U 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1.5 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course o 29a. Certifier ind/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

one)

29b. Signature and title of certifie

30. Name and address of per-

31. Date filed (Month, Day, Year)

29c. License number

7944

29d. Date signed (Month, Day, Year)

254

2006

and manner stated

32. Registrar's

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| rudi 1002yilaki | | State of Maryland / Departme 1- For State Certifica Registrar | te of Death | ygierie Reg. No | 200 | 9 0936 |
|--|----------------|--|---|--|--------------------------------------|--|
| Physicia Medical Examir | n/ | 1. Decedent's Name (First, Middle,Last) Trudi Ann Kuczynski | | 2. Date of Death Month Day March 23, 200 | | 3. Time of Death 1910 hrs |
| | | 4a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4 | c. County of Death | |
| <i>)</i> Funeral | | Laurel Regional Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth) | day) If Under 1 Year If Under 24Hrs. | | Prince George' | S oplace (State or Foreign |
| Director | | 006-44-9132 _{1 M 2XF 63} | Yrs. Months Days Hours Min. | - | 45 Cou | ntry) NY |
| , and | | Usual Residence of Decedent 10c. City, Town or 10a, State 10b, County 10c. City, Town or | | | | 10d. Inside City Limits |
| | to | MD Howard Laurel | | | | 1 Yes 2 No |
| the Mary | Director | 10e. Street and Number 29 Center St | 10f. Zip Code 20723 | U . S | A. | try? |
| ath with tems 23 st be no | Funeral | 1 Never Married 2 Married Armed Forces? | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | | 14. Race - Americ White, etc. | can Indian, Black, |
| after de | by Fu | 3 Widowed 4 Divorced If Yes, 2 No | 1 Yes 2 X No specify: | | Specify: Whi | te |
| 2 hours "natur | ted t | Flementary/Secondary (0-12) College (1-4 or 5+) | ecedent's Usual Occupation (Give kind of wuring most of working life. DO NOT use reti | | Kind of Business/Ir | ndustry |
| 0036 within 7: ene. er than | Be Completed | 5 Sch | ool Teacher | | blic/Pr | ivate |
| 21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medical | | 17. Father's Name (First, Middle, Last) Herbert H. Stroup | Grace G | (First, Middle, Maider Guldin | n Surname) | |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland and of Hygiene. Out: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be neitled at once. | ٩ | 19a. Informant's Name/Relationship (Type, Print). 19b. 29 19b. 29 | Mailing Address (Street and Number or F Center St, Laur | Rural Route Number, C | Dity or Town, State, 0723 | Zip Code) |
| ore, N s 1 and of Health If item | | | Disposition (Name of cemetery, ry or other place) | Date 20c. | Location - City or | Town, State |
| Baltimore, permit. Pages Lar Department of Hee Important: If ite injury or other tr | | 4 Donation 5 Other Specify: Chesa | peake Crem. 3/2 | .5/2009 B | eltsvil | le, MD |
| Ba perm Depa Imperiment | | 21 Signature of Funeral Service Licensee Mo 1443 23a. Part I. Enter the disease, or complications that caused the death. Do not | 22. Name and Address of Facility CAF | A/Stephe ures Dr. | n D Loh Towson. | rmann P.A <u>MD. 21286</u> |
| Physician /Medical | | failure. List only one cause on each line. | | r respiratory arrest, si | ock, or heart | Approximate Interval Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) a. Congestive heart Due to (or as a consequence of): | | | | |
| | Jer | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | liovascular disease | | | |
| | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | |
| 760, icate be executed physician and the burial - transit | | d. X UNPENDED AMENDED PI line a-h | o, PII,27,perME, g89 | 02 6/4/09 | ΓŤ | |
| 760, icate be physici the buri | | IF FEMALE: 23c. If yes, outcome of pregnancy | | | Bd. Date of delivery | |
| Box 687 e death certific the attending p | Physician/ | past 12 months? 1 | Fetal death 3 Ectopic pregna Other (Specify) | ncy | Month D | ay Year |
| O.O. Bc that the dea ned by the a detached fo | Phys | Part II. Other significant conditions contributing to death but not resulting | in the underlying cause given in Part I. | 23e. Did tobacco | use contribute to t | he cause of death? |
| S, P.(uires that signed d be deta | ed by | Morbid obesity | | 1 Yes 2 | ✓ No 3 Prob | ably 4 Unknown |
| cords, law requir has been s | Completed | Diabetes mellitus | | 24a. Was an autopsy performed? | prior to co | opsy findings available ompletion of cause of |
| Vital Rec ysician: The l his certificate b director, page | | 25. Was case referred to medical | 26.Place of Death (Check | 1 ✔ Yes 2 | No 1 🗸 Ye | s 2 No |
| of Vitaing Physicis After this ce | To Be | 1 tes 2 1140 | | | ence 6 Other | |
| on o ending ath. or: Afte | tion: | 1 X Natural 5 Pending (Month, Day, Year) | me of Injury 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how in | jury occurred | |
| Division of Vital Records, P.O. ted or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | Certification: | Suicide 6 Could not be | m, street, factory, office building, etc. | 28f. Location (Street or Town, State) | and Number or Run | al Route Number, City |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | | 4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat | h occurred at the time, date and place, and | due to the cause(s) a | nd manner as state | ed. |
| To the within To the comple | Medical | one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier | vestigation, in my opinion, death occurred a | | ace, and due to the Date signed (Mon | |
| | | (/Carluleud) | O.C.M.E. | | rch 24, 2009 | un, Daj, realj |
| OK PENC | İ | 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 | Penn Street, Baltimore, MD 212 | | | |
| | ate | 21 Date filed (A by South State) | 100 | | | |
| Regist | rar | FIRST ~ COURT COMMENT A. | barked | | | |

DHMH 17 Rev 1/2001 OCME 2006

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 **Physician** CHARLES THEODORE KERNS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A f Under Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) al Security Number **Funeral** Hours Months Days **X**XM 2□ F 217-12-2112 89 10/29/1919 MARYLAND **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ust be notified at 1 ☐ Yes 2♥ No PARKVILLE BALTIMORE Directo MD 28a-1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 items 23a 21234 USA 1735 AMUSKAI ROAD by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 □ Yes 2 🔀 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PIPE LINE MECHANIC GAS & ELECTRIC 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Pages 1 and 2 should be nent of Health and Mental မ REBECCA C. COATES HARRY R. KERNS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a important: If Item 27 is any injury or other trai once. 1735 AMUSKAI ROAD BALTIMORE. MD JEAN KERNS/WIFE 20c. Location - City or Town, State 20a. Method of Disposition DULANEY VALLEY MEM 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State COCKEYSVILLE, MD 3/25/2009 | 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licensee MO11139 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Do not enter the mode of dying, such as cardiac or respiratory arrest,

Manager Ala (In faction Approximate Interval Between Onset and Death 23a. Fart 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Yno cardial Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himiculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🗷 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00058570 March 21, 2009 Good Sana- tan Huspital Baltimure 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrance L. Baker MD 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State BOAKA Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year EE, EKIKI9 MONTH MARCH 3:37F JENNIE ELEANOR ROOSENDAAL KEARNEY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Saint Joseph Medical Center Towson 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day June 17 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) , 1923 North Dakota Days Min 1 □ M 2 🔽 F 85 362**-**24-**7**499 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 No Lutherville Maryland Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 1526 Norman Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Spice Manufacturing Elementary/Secondary (0-12) 12 College (1-4or 5+) Bookkeeper Company 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Poste Martha William Roosendaal

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

1030 Hidden Moss Drive, Hunt Valley, Maryland 21030

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

-22-09

DISTER DRIVE TOWSON MARYLAND 21204

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macteral Examination and the notified at Director Funeral 72 hours after Baltimore, Maryland 21215-0036 þ Completed d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n Be ဥ permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 is n
any injury or other traun
once.

Physician

/Medical

Examiner

10a, State

19a. Informant's Name/Relationship (Type. Print)

20a. Method of Disposition

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Striatur

Sharon A. Kearney (Daughter)

Funeral

Director

Physician /Medical Examiner

Examine attending physician and for use as the burial-transit Physician/Medical certificate has been signed by the rector, page 2 should be detached þ Completed funeral director, Be Certification: To After t 24 hours after death Funeral Director: filled in by Medical completely within 2

or Attending Physician: The law requires that the death certificate be executed

the Hospital

P.O. Box 68760,

Division of Vital Records,

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Grdns 3/26/09 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur V Funeyal Service ee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ISCHEMIC BOWE disease or condition resulting in death) Due to (or as a consequence of): OBSTRUCTION WITH PERFORATION SMALL BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 Probably 4 Unknown LUNG CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA |
Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

State Registrar

D 31826

NIC.LL

| | | 1 - For State Registrar | | State | of Ma | ryland | / De | epartment Certificate | of F | lealth Deat | n and M h | 1ental H | ygien Reg. No | 200 | 9 | 093 | 58 |
|--|----------------|--|---------------------------------|---------------------------------------|--------------------------|---|------------------|--|-------------------|--------------------|--------------------|--------------------------------------|------------------------------------|-------------------|------------------|---|-------------------|
| | | 1. Decedent's Nam | ne (First, Middle, | Last) | | | | - | | | - | 2. Date of D | eath Da | av V | ear | 3. Time of De | eath |
| Physic /Medi | | Robert | Joseph | Laing, S | r. | | | | | | | March | 24 | | | 10:13 | a ^M |
| Exami | ner | 4a. Facility Name (| | | umber) | | | | | | on of Death | | 40 | . County of | Death | | |
| _ | | Holy Cro | | ital B. Sex | 7. Age | (In yrs. las | st birtho | Silv | | | ing ler 24 Hrs. | 8. Date of B | | Montg | | ace (State or F etry) | Foreign |
| Funeral Director | | 220-36-3 | | 1 ∑ M 2□F | lge | 7(| | Months | Days | Hour | s Min. | 8. Date of B (Month, I Nov • 1 | ay, Year 0,19 | | Coun | MD | J |
| pu , | | Usual Residence of | | | | 10- 0:1- | T | al costion | | | | | | | 1 | 0d. Inside City | Limite |
| aryłau show | 'n | 10a. State | 10b. County Howar | a | | 10c. City, | | r Location | | | | | | | ' | od. mside City 1 □Yes 2 | |
| the M 28a-f notifie | Director | MD 10e. Street and Nu | | u | | Savag | Je | 10f. Zip (| Code | | | | 10g. C | itizen of Wh | at Cour | itry? | |
| 3a or | Ö | 8876 Bal | | St. | | | | 1 | 763 | | | | US | A | | • | |
| death | Funeral | 11. Marital Status | | 12. Was De | cedent E | ver in U.S. | | 13. Was Decede If Yes, speci | ent of H | lispanic | Origin? (Sp | ecify Yes or N | lo- | 14. Race - | | | |
| DEJILITIOFE, INTERTIBLIC ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Model at the most permitted at once. | by Fu | 1 ☐ Never Mar | ried 2⊠ Marrie 4 □ Divorced | | 2 No | 0 | | 1 ☐ Yes 2 | | Speci | | riican, etc.) | Black, White, etc. Specify: white | | | | |
| 72 ho | Completed | (Spe | 15. Decedent's | Education grade completed | i) | | 16a. D | ecedent's Usual Give kind of work fe. DO NOT use | Occup | ation | nost of work | ing | 16b. I | Kind of Busi | ness/Ind | dustry | |
| vithin whe. | Id m | Elementary/Sec | | 1 | (1-4or 5+ | .) | | ery Cle | | d) | | 5 | Gro | cery | Stor | ~ <u>~</u> | |
| Illed w Hygie Hygie ther t | ပ္သ | 17. Father's Name | (First, Middle, L | ast) | | | 3100 | oci y cic | | 18. Mo | other's Name | e (First, Middi | | | | | |
| yland suld be file Mental H arked oth attic even | To Be | | | ld Laing | r | | | | | Ma | arie E | Barbara | McI | ntyre | | | |
| shou and M s mar | - | 19a. Informant's N | lame/Relationshi | p (Type. Print) | | | 19b. M | Mailing Address (| (Street | | | | | _ | ate, Zip | Code) | |
| and 2 sl and 2 sl ealth an n 27 is i | 1 | Brenda I | Lee Lain | g/ wife | | | | 6 Balti | | | | | | | | _ | |
| nore | | | , | B ☐ Removal from | n State | 1 | | isposition (Name crematory or other UMC C | | ce) | Marc | o _{ate} ch 26, 109 | | ocation - Ci | | | |
| DAILLINO Permit. Pages Department of mportant: If it any injury or conce. | | 21. Signature of F | | | | | inue | 22. Name and | Addre | | cility Don | aldson | Fun | eral i | Home | | |
| _ ¥0 = # 0 | 1 | Liten | Slike | | | 1053 | _ | 313 Ta | | | | | | 2070 | 7 | Annuarimete | |
| | | | art failure. List o | omplications that nly one cause on | each line | the death. e. | Do no | t enter the mode | of dyin | ng, such | as cardiac | or respiratory | arrest, | | | Approximate Interval Betwe Onset and De | en ath |
| Physician /Medical | - | Immediate Cause disease or conditi resulting in death) | on | - | | | _ | atory f | ail | ure | | | | | | | |
| Examiner | | | | | , | conseque | | : neumo | nia | | | | | | | | |
| | ĕ | Sequentially list contains to it cause. Enter Und Cause (Disease o | onditions, | b. Due to | (ur as a | t CultiSeque | nee of) | i | ni Lu | | | | | | | | |
| acuted ind | Examiner | that initiated event | S | C | Can | | | | | | | | | | | | |
| ficate be exemple the properties of the purial- | a E | resulting in death) | Last | Due to | o (or as a | conseque | nce of) | : | | | | | | | | | |
| oo/ ficate physis the | edical | | · | d | | | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit | Physician/M | IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown | 2 months? □No | | e birth 2 gnant at | of pregnand 2 ☐ Fetal d time of dea | leath | 3 ☐ Ectopic pre 5 ☐ Other (spe | | у | | | | 23d. Date Mont | | ery Day Yea | ar |
| that ned by deta | by Ph | Part II. Other sign | ificant condition | s contributing to | death bu | t not resulti | ing in th | ne underlying ca | use giv | en in Pa | rt I. | 23e. Did | tobacco | use contrib | ute to th | ne cause of dea | ath? |
| quire; en sig | ed b | hyponatr | remia | | | | | | | | | 11/2 | Yes 2 | 2 □ No 3 | ☐ Prob | oably 4☐ Uni | known |
| hecords, The law requires tet has been signe | Completed | chronic | obstruc | tive pul | mona | ry di | isea | ıse | | | | per | s an opsy formed? 2 \ N | pri- de: | or to co ath? | psy findings av mpletion of cau | ailable ise of |
| Italian: sian: striffice ettor, p | Be | 25. Was case refe examiner? | rred to medical | 3: | | | | - | , | | | h <i>(Check onl</i>) | one) | | | | |
| OT V Physic rthis ce | ြုင | 1 ☐ Yes 2 🙀 | | 1 | - ' | | | atient 3 DO/ | A Oth | er: 4 🗆 | | ome 5 □ Re | | | | y) | |
| Jn C | ion | 27. Manner of Dea | ith 5 ☐ Pending investiga | (Mo | e of Injur onth, Day, | y ; <i>Year)</i> 2 | 28b. Tin Inju | ne of 28 ury M | Bc. Injur Worl | yat k? Yes 2 | | 28d. Describ | e how inju | iry occurred | | | |
| IVISION or Attending frer death. Director: Afte | Certification: | 2 Accident 3 Suicide 4 Homicide | 6 Could no determin | ot be 28e. Plac | | ry - At hom . <i>(Specify)</i> | | , street, factory, | | 163 2 | | | (Street a | | or Rura | l Route Numbe | <i>∋r</i> , |
| Hospital of the Post of the Po | edical Ce | 29a. Certifier (Check only one) | | Physician: To the | | examination | | | | | | | | | | | |
| o the vithin o the | Mec | 29b. Signature and | d title of certifier | and me | initer stat | lou. | | 29c. | Licens | e numbe | er | | 29d. D | ate signed (| Month, | Day, Year) | |
| - > - 0 | | • | 5 | | | | N | D | 525 | 03 | | | Ma | rch 24 | 1, 2 | 009 | |
| | | 30. Name and add | | | | | | | Ci | 1,000 | Snri | na MD | 200 | 1.0 | | | |
| St | tate | 31. Date filed (Mo. | | 38 | Registra | r's Signatu | re | | DT. | T v et | . PALT | ny, MD | 209 | Τ.Ο | | | |
| Regis | | M | AR 2.5.21 | 109 / | in | . A. | 1 | ale | | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 1:00 PMM Barbara Ann Lefkow March 21, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4928 Sentinel Dr. #301 Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🗷 F 81 Director 477-24-1742 05/03/1927 MN Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 □Yes 2 No Director MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 4928 Sentinel Dr. #301 20816 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after the the that hand Mental Hygiene.
Sem 27 is marked other than "natural", or iten ther traumatic event, the modical Evantics. 1 Never Married 258 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: 2 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Medical Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adelbert Vine Maude Toogood ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Leonard Lefkow/Husband 4928 Sentinel Dr. #301 Bethesda, MD 20816-If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Mar 24 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland 2009 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARCINOMA UNRNOWN 14 MONTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes 2 No certificate 1 ☐ Yes 1 Tyes 2 No Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29b. Signature and tipe of contifier 29d. Date signed (Month, Day, Year) 29c. License number MARCH 23, 2009 D.23600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR, BRUCE R. KRESSEL WISCONSIN AVE CHEVYCHASE

Registrar

State

32. Registrar's Signature

| | | | amend #5 Per INF & | 891 \SYT3\09\^; | Certificate of L | Death | Reg. No. | 2009 | 09370 |
|-------------------|--|----------------|--|--|---|---|---|-------------------------------------|--|
| ۳ | Physici | an | 1. Decedent's Name (First, Middle, Last) | to | | | Date of Death Month Day | Year | 3. Time of Death 2 10 PM |
| | /Medic | al | 4a. Facility Name (If not institution, give stree | 12V | 4b. City. Town, or | Location of Death | | 2009 County of Death | 2,101 |
| 7 | Examir | er | 1 established | sing Hom | e BAL | timore | | NIA | |
| | Funeral Director | | 5. Sooral Recuting Number 5 6. Sex 13. M Usual Residence of Decedent | 7. Age (In yrs. last b | oirthday) If Under 1 Year Months Days | | Date of Birth (Month, Day, Year) May Le [| 9. Birth Cou | place (State or Foreign ntry) Lry land |
| | land ow It | | 10a. State 10b. County | | wn or Location | | | | 10d. Inside City Limits |
| | the Mary 28a-f sh | Director | Maryland N/A | Ba 17 | 10f. Zip Code | | 10g. Citi | zen of What Cou | 1 Yes 2 □ No |
| | ath with s 23a or nust be r | | 3915 Belview | | D 2 | 1215 | 6 | 1-5-A 14. Race - Ameri | ·, |
| 9800 | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | d by Funeral | 1 Never Married 2 Married 1 | Vas Decedent Ever in U.S. irmed Forces? ☐ Yes 2 1 No Yes, Give lear or Dates: | 13. Was Decedent of Hi If Yes, specify Cuba | Specify: | an, etc.) | Black, White, | etc. KCK |
| 21215-0036 | within 72 h ene. than "natu he Medical | Completed | 15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12) | | a. Decedent's Usual Occupa (Give kind of work done of life DO NOT use retired | luring most of working | . 1 | nd of Business/Ir | ndustry |
| | iled wi Hygien ther th | | 17. Father's Name (First, Middle, Last) | | Jantoria | 18. Mother's Name (F | CE T | Surname) | <u>e</u> |
| Maryland | lid be lental ked o | To Be | 0 1 1 | caster | | Faith | Gou | ah | |
| lary | d 2 should th and Mer 7 is marke traumatic | | 19a. Informant's Name/Relationship (Type. F | | 9b. Mailing Address (Street | and Number or Rural R | loute Number, City o | r Town, State, Zi | p Code) |
| - | s 1 and 3 if Health item 27 other tr | | 20a. Method of Disposition | Mo Hev | 3915 B | elulew 1 | Apr. 12/ | ocation - City or T | A Ho. /MB |
| Baltimore | g = 5 | | 1 Burial 2 ☐ Cremation 3 ☐ Remo | como | tery, crematory or other place | | 7-09 /00 | dedicate | we Man |
| altir | in production | | 21. Signature Fineral Service Licensee | | 22. Name and Address | as a Facility | ennuni | ty funy | Al Home P |
| ä | Dep Imp any | | 1800 | | 1206 W | DOITHAU. | ei | | |
| | | . 4 | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car | use on each line. | | g, such as cardiac or re | espiratory arrest, | j. | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Sersis Due to (or as a consequence | | | | | one month |
| | Examiner | | 2 1970 42 | eriheratie | | takes po | st drain | wage a | one month |
| | pi ii | iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence | enoleeystec | 1 | | 0 | one month |
| d | tificate be executed g physician and as the burial-transit | Examiner | that initiated events resulting in death) Last | Due to (or as a consequence | enoteeystec | formy and. | explorator laparo | 1-11-11 | |
| 68760, | e be e sician e buriż | | d. | | | | laparo | lowed | |
| | rtificate ng physias the | Medical | IE ECHALO. | | | | | | |
| O. Box | The law requires that the death cert the has been signed by the attending tage 2 should be detached for use it | Physician/№ | in the past 12 months? | f yes, outcome pf pregnancy I □Live birth 2 □ Fetal dea t□ Pregnant at time of death I□ Unknown | | | | 23d. Date of deliv Month | rery Day Year |
| , P.O | s that the de ned by the a detached is | | Part II. Other significant conditions contribu | | | | 23e. Did tobacco u | use contribute to | the cause of death? |
| ords | w requires been sign should be | ed b | Metastatie | Prostate | cancer, He | patitis e | 1 □ Yes 2 | K No 3□ Pro | bably 4 □Unknowr |
| or Vital Records, | The law rate has be page 2 shu | Completed by | | | | | 24a. Was an autopsy performed? 1∐ Yes 2 ☑ No | prior to co death? | opsy findings available ompletion of cause of 2 No |
| /ita | sician: The certificate rector, pag | Be | 25. Was case referred to medical examiner? | tall and | Tou. | 26. Place of Death (C | | | |
| or | Phys this aldi | 2 | 1 ☐ Yes 2 ☐ No Hosp 27. Manner of Death 2 | 1 Inpatient 2 EH/C | Outpatient 3 DOA Oth | 4 □ Nursing Home | 5 Residence | | ify) |
| on | After After fune | tion | 1 ANATURAL 5 Pending 2 Accident investigation | (Month, Day Year) | Injury Worl | Yes 2 □ No | a. Describe flow injur | y occurred | |
| Division | al or Attend after death Director: / d in by the f | Certification: | a□ cuiside 6□ Could not be | 8e. Place of injury - At home, building, etc. (Specify) | farm, street, factory, office | 28f | . Location (Street an City or Town, State | | ral Route Number, |
| ス | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | 29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner: | n: To the best of my knowled On the basis of examination and manner stated. | lge, death occurred at the tir and/or investigation, in my c | ne, date and place, and pinion, death occurred | d due to the cause(s) at the time, date and |) and manner as d place, and due | stated. to the cause(s) |
| | To the within To the Comp. | Me | 29b. Signature and title of certifier | Egew, M | 29c. Licens | 005392 | 28 03 | te signed (Month | |
| | | | 30. Name and address of person who completely and the second of the seco | eted cause of death (Item 23a | (Type, Print) SUR | AIYA B | EUZUM, | MD | |
| | ے St | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | # 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 / 1 | | | , , | |
| | Regist | rar | MAR 2 5 2009 | Deserve A. | parle | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month March 20, Chester William Morris 2009 9:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 🖾 M 2 🗆 F Hours Min Director 579-05-0287 91 21, Apr 1917 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Hedical Examinatina two raffiled at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ofris ChostM 3/201 Baltimore, Maryland 21215-0036 5 Brookings Court Funeral 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No 2 Specify: Specify: White 3 ☑ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Automobile Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Morris ပ Lillian Herrel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any Injury or other trau Lillian J. Trautfelter /daught|. P.O. Box 28313, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Mar 24, 09 Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the cises e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart (Aur. List only one cause on each line. Immediate Cause (Final Onset and Death **Physician** EllieNI YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate fly Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) executed and Due to (or as a consequence of): burial Box 68760, physician certificate be Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) #05F1C1 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 □Yes 2 🗆 No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) To the 29b. Signature and title of certifie 764395 MARCH 21,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHANES ST, 8WIR-209 BALTIMORE, MD 21204 DOBERMAN, MO DANIELLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 23 rd 2009 McCoru GIO AM March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Randallstown Baltimore Gensis Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F Date of Birth (Month, Day, Year) 7–22–1959 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 216-66-7151 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Lochern 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 7215 North Alter Street USA 12. Was Decedent Ever in U.S. Armed Forceş? 1 ∐ Yes 2 ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 □ Never Married 2 □ Married 1 ☐ Yes 2 📉 No Specify. specify: African-American 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker 10th Becton Dickinson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert C. McCory Phyllis J. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7215 North Alter Street, Lochem MD 21207 Phyllis J. McCory/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State Arbutus Memorial Park 3-28-09 4 ☐ Donation 5 ☐ Other (Specify) Arbutus, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Barto. Co. 21. Sign ture of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic adenocarcinoma of the Lung Due to (or as a consequence of): Metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): thrombou Due to (or as a consequence of): severe anernia IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Moursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MD

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" or items 23a or 21 any injury or other traumatic event, the Medical Examinar mind once.

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

requires that the death certificate be executed

attending physician and for use as the burial-trar signed by the a d be detached f page

P.O. I

or Vital Records,

Division

Examiner this certificate

Physician/Medical Completed by To the Hospital or Attending Physician: 2 within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral Certification:

> State Registrar

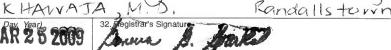
DHMH 17 Rev 1/2001

Medical

31. Date filed (Mont

determined

30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9109

29c. License number

D0058965

Liberty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Jean Elaine McKee 2009 3:05 March 23, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13113 Larchdale Road, #1 Laurel Prince George 8. Date of Birth (Month, Day, Ye Sept 12, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 💢 F Hours Min Year! 213-78-5037 51 1957 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13113 Larchdale Road, 20708 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 □ Yes 2 🔯 No Black, White, etc. 1 ☐ Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🗵 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) George Knobl Irene (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13113 Larchdale Road, #1, Laurel, Maryland 20708 William E. McKee /spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ivy Hill Cemetery Mar 30, 09 Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause I inadisease or condition resulting in death) Onset and Death 6yrs 5mos Due to (or seguence of) Sequentially list conditions, if any, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show

Director

Funeral

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Completed

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MD

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

permit.

executed

certificate be

law requires that the death

Hospital or Attending Physician: The

death. after death Director: din by the f

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

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certificate

After thi funeral of

Box 68760.

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Division of Vital Records,

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Its IM.

Baltimore, Maryland 21215-0036

/Medical

burial-trans and attending physician the use õ signed by the page 2

Examiner Physician/Medical ð Completed Be မှ Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certif

5 Pending

investigation

determined

6 ☐ Could not be

29c. License number 0059292 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) 7350 VAN Dress (Ld, Lau aurel

28a. Date of Injury (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Medical

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend #7 & Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Harold E. Mack /Medical March 22 2009 2:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Joseph Richey Hospice Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 941 Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 9468 Director 12/22/1914 216-36-5031 Maryland Usual Residence of Decedent alth and Mental Hygiene.

alth and Mental Hygiene.

1.27 is marked other than "natural", or Items 23a or 28a-t snow.

***aumatic event, the Medical Expriner coust be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 1501 Mosher Street 21217 U.S.A 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?
1 ☐ Yes 2 📉 No 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James D. Mack Francis Jefferson Department of Health and Important: If item 27 is ma any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5130 Arbutus Avenue, Baltimore, Maryland ace of Disposition (Name of Date 20c. Location - City or 1 <u>Margaret E. Owens / Sister</u> altimore, 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Park Ceme. 03/27/2009 Baltimore, Maryland 22. Name and Address of Facility
The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic lung cancer (non small cell disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) physician 68760 pe Physician/Medical the as attending properties for use as IF FEMALE P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the 1 Yes 2 No 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a Was an autopsy performed? Yes 2 No certificate Vital 1 □ Yes 2 **1**No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To of 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending 1 Natural Division 5 Pending investigation he Funeral Director: After Actions after the Funeral Director of the funeral filled in by the funeral 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To th. within 24 (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D51788 3-23-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Polk 620 Boulton St. Bel Air MD 21014 Tim 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 5 2009 Registrar

DHMH 17 Rev 1/2001

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MAC

AROLD

09-02156 Kim Macklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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| | | | | | | | | |

| | Registrar | | cate of Death | | Reg. No. | |
|--|--|--|--|--|--|--|
| Physician/ Medical Examiner | / / / / / | ice Mack | <lin< td=""><td>Mont</td><td>of Death h Day Year ch 17, 2009</td><td>3. Time of Death 0415 hrs</td></lin<> | Mont | of Death h Day Year ch 17, 2009 | 3. Time of Death 0415 hrs |
| | 4a. Facility Name (if not institution, giv Johns Hopkins Hospital | e street and number) | 4b. City, Town, or Lo Baltimore | ocation of Death | 4c. County of | Death . |
| Funeral Director | 5. Social Security Number 6. S. 217-90-7885 1 | | 9 Yrs. If Under 1 Year Months Days | Linuary Man | e of Birth (MM/DD/YYYY) -9-1969 | 9. Birthplace (State or Foreign Country) //// Arcyland |
| d how any: | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Tow | n or Location Himoree | | | 10d. Inside City Limits 1 Yes 2 No |
| uth the Maryland 23a or 28a-f show inotified at once. | 10e. Street and Number | EAL Street | 10f. Zip Code | <i>'</i> 3 | 10g. Citizen of Wha | |
| after death with the Maryland ni", or items 23a or 28a-f she iner must be motified at once 3y Funeral Director | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U.S. | 13. Was Decedent of Hispa | anic Origin? (Specify Ye Mexican, Puerto Rican, e | s or No- 14. Race - etc.) White, | American Indian, Black, etc. |
| | 15. Decedent's Education (Specify or | | 1 Yes 2 No : a. Decedent's Usual Occupation during most of working life. D | (Give kind of work done | e 16b. Kind of Busi | |
| 36 in 72 han ' | Elementary/Secondary (0-12) 12. 17. Father's Name (First, Middle, Last | College (1-4 or 5+) | Houseke | eping | 1/ea/ | h Care |
| Tore, MD 21215-0036 signs I and 2 should be filed within 72 nt of Heakh and Mental Hygiene 1: If Item 27 is marked other than other trainmatic event, the Medical To Be Complet | Odel Richards Name/Relationship (1 | chardson | | Dokethk | LA ROSE | The second secon |
| P, MD and 2 short fealth and trem 27 is trainmatic | CIERRA, KING | Daughter) | 2207 E 1 e of Disposition (Name of ceme | tederal | Street | Bacto Md. City or Town, State |
| 6 a a a | 1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature Finer Service Vice | Removal from State crem | atory or other place) ount Carmel | 3/21 | 109 Balt | o. md. |
| Balt Balt Depart Import Import Injury | 23/ Part I. Enter the disease of comp | wellen | 22. Name and Address of | BROadier | ry Bullo | Md · 2/2/3 Approximate Interval |
| /Medical xaminer | failure. List only one cause on ea | | | | | Between Onset and Death |
| ner | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of): | | 4 | | <u> </u> |
| xecuted n and - transit cal Examine | (Disease or injury that initiated C. | Due to (or as a consequence of): | | | | |
| = <u>a a a</u> | X UNPENDED | , | rME, g890 4/27 | 7/09 TT | 22d Date of d | |
| | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknowr | 23c. If yes, outcome of pregnand Live birth 4 Pregnant at time of death 9 Unknown | | Ectopic pregnancy | 23d. Date of d Month | Day Year |
| ries that the death cer signed by the attendi be detached for use detached by Physicia | Part II. Other significant conditions | contributing to death but not result | ing in the underlying cause give | | | ute to the cause of death? Probably 4 Unknown |
| Division of Vital Records, P.O. Box 6 pairs in the death cerbours after death. Division of Attending Physician: The law requires that the death cerbours after death. Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use Certification: To Be Completed by Physicia | | | | | autopsy pri performed? de | ere autopsy findings available or to completion of cause of ath? Yes 2 No |
| ital Filtinations: Secretifications of the Control | 25. Was case referred to medical examiner? | lospital: 1 Innation: 2 4 EP/ | | Death (Check only one) | | |
| of Ving Physical Control of Contr | 1 Yes 2 No 27. Manner of Death | Impatient 2 Civ | Outpatient 3 DOA Time of Injury 28c. Injury 8 | | 5 Residence 6 scribe how injury occurred | Other: |
| ision Attendin r death. ector: A by the fu | 1 X Natural 5 Pending 2 Accident Investigati | 28e Place of Injury - At home | 1 Yes | s 2 No | otion (Street and Number | or Rural Route Number, City |
| Division o spital or Attending spital or Attending hours after death hours after death hours after death hours after death hours after death filled in by the fune Certification: | 3 Suicide 6 Could not determined | be | rami, sireet, factory, office built | | Fown, State) | or Rural Route Number, City |
| within 24 To the Fu completely | one) 2 Medical Examiner | an: To the best of my knowledge, dOn the basis of examination and/or and manner stated. | r investigation, in my opinion, de | eath occurred at the time | e, date and place, and due | e to the cause(s) |
| . | 29b. Signature and title of certifier | 1977 | 29c. License n | | 29d. Date signed March 17, 20 | (Month, Day, Year) |
| 4 | 30. Name and address of person who of Zabiullah Ali, M.D. Assis | |) 111 Penn Street, Baltim | ore, MD 21201 | | |
| State Registrar | A | 2. Registrar's Signature | parket | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donald Merritt /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner Saltimor dale | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Mogth, Day Hours Min. | 4. March 10, 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1⊠M 2□ F 220-22-7261 Maryland Yrs Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d, Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1201 Hillshire Road 21222 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Specify: White 1 □Yes 2X No Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 years Crane Operator Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Merritt ဂ္ Anna Pfisterer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Shirley Merritt 1201 Hillshire Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 26 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of uneral Service kin ns ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3/14/09-3/21 Due to (or as a consequence of): Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed 2 🗆 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records,

Funeral

Director

or items 23a or 28a-f show

event, the Medical Exa.

'natural",

s 1 and 2 should be filed within if Health and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked 1 any intry or other traumatic evonce.

Physician /Medical

Examiner

and burial-trar

attending physician for use as the buria

the detached

signed b

page 2 should

director,

death.

To the Hospital within 24 hours a

vithin 24 hours after death

o the Funeral Director:
completely filled in by the

72 hours after death with the Maryland

filed within

Maryland 21215-0036

Saftimore,

31. Date filed (Month, Day, State Registrar

29b. Signature

Franklin Square Dr. Bathimore, MD 21237 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| iridia Mazziott | | 1- For State | | cate of De | | | eg. No. 200 | 19 0937 | |
|--|------------------|---|-----------------|-------------------|--|----------------------------------|----------------------------------|----------------------------------|--|
| Physicia | an/ | Registrar 1. Decedent's Name (First, Middle,Last) | | | | 2. Date of Dea | ith | 3. Time of Death | |
| edical Exami | ner | Sandra | M | azziott | | Month March 23 | | 0111 hrs | |
| | | Facility Name (if not institution, give street and number) Johns Hopkins Bayview | | | y, Town, or Location Itimore | of Death | 4c. County of Dea | th | |
| Euporal | | · · · · · · · · · · · · · · · · · · · | (In yrs. last b | | | er 24Hrs. 8. Date of Bi | rth(MM/DD/YYYY) 9. B | irthplace (State or | |
| Funeral Director | | 218-70-9420 1_M 2\overline{X}F | 52 | Mo | onths Days Hours | s Min. | ` Fore | | |
| any | | Usual Residence of Decedent 10a. State 10b. County 1 | Oc. City. Toy | n or Location | | | | 10d. Inside City Limits | |
| * . | | Delaware Sussex | | Millsb | oro | | | 1 Yes 2 X No | |
| Maryland 28a-f show d at once. | cto | 10e. Street and Number | | | Zip Code | 1 | l0g. Citizen of What Co | untry? | |
| oith the Maryland 5.23a or 28a-f show enotified at once. | Dire | 27925 Home Farm Drive | | | 19966 | | USA | | |
| with ms 23. be no | eral | 11. Marital Status 12. Was Decedent E | ver in U.S. | | edent of Hispanic Ori | gin? (Specify Yes or No | 14. Race - Ame | rican Indian, Black, | |
| death or ites must | Funeral Director | | X No | | ecify Cuban, Mexicar | | White, etc. | | |
| hours after 'natural'', Examiner | by | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | | | 2X No specify | | Specify: Wh | | |
| | Completed | 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+ | | | ual Occupation (Give working life. DO NOT | | 16b. Kind of Business | mustry | |
| 5-0036 led within 72 Hygiene. other than ' | nple | 12 years | · | Sales As | ssociate | | Clothin | g | |
| 5-0(led wi Hygier other | | 17. Father's Name (First, Middle, Last) | | | 18.Mothe | r's Name (First, Middle, | Maiden Surname) | | |
| 21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica | Be | Francis Mazziott | | | | nne Bowman | | | |
| AD 2 sho 2 sho 27 is | 2 | 19a. Informant's Name/Relationship (Type, Print) Dianne Mazziott Mother | 1 | 27925 но | ome Farm D | rive, Mills | mber, City or Town, Sta | 19966 | |
| re, N s I and of Healti If item | | 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State | crem | atory or other pl | | March 25, | 20c. Location - City o | or Town, State | |
| Page Page ment o | | 4 Donation 5 Other Specify: | Bayv | iew Cre | _ | 2009 | | , Maryland | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr | Ш | 21. Signature / Funeral Service Lizen & | | 22. Name Coni | and Address of Facility Fune | ral Home Of | Dundalk,P Dundalk,M | .A. | |
| Physician | | 23a/Part I. Enter the disease, or complications that caused the | ne death. Do | not enter the mo |) Sollers de of dving, such as o | Point Road, | Dundalk, Morest, shock, or heart | d. 21222 Approximate Interval | |
| Medical | . 29 | faiture. List only one cause on each line. | | | | | ood, ongon, or nounc | Between Onset and Death | |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence) | | tic Cardiovas | Sculai Discase | | | | |
| | L | Sequentially list conditions, b | | | | | | | |
| | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | quence of): | | | | | | |
| \ = \ \ = | xan | (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq | quence of): | | | | | | |
| executed an and al - transit | | d | | | | | | | |
| | Medical | UNPENDED AMENDED | | | | | Loo - Data of dall | | |
| | an/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth | e of pregnand | y 2 Fetal de | ath 3 Ectopi | ic pregnancy | 23d. Date of delive Month | Day Year | |
| Box 687 e death certific the attending p | sicis | 4 Pregnant at til | me of death | 5 Other (| Specify) | | | | |
| the de | Physician/ | Part II. Other significant conditions contributing to death I | but not result | ing in the under | ving cause given in P | art I. 23e. Did t | obacco use contribute t | o the cause of death? | |
| P.O | ρ | Multiple Sclerosis, Chronic Obstructive Pul | | • | | | s 2 No 3 Pr | obably 4 🗸 Unknown | |
| rds, requir | Completed | | | | | 24a. Was | | autopsy findings available | |
| e law e has l ge 2 sh | ldm | | | | | | ormed? death? | | |
| tal Records, cian: The law requir certificate has been s ector, page 2 should | | 25. Was case referred to medical | | · | 26.Place of Death | 1 Yes | 2No1 🗸 ` | Yes 2 No | |
| Vital hysician: this certiful director, | To Be | examiner? 1 Ves 2 No Hospital: 1 Inpatient | t 2 🗸 ER | Outpatient 3 | DOA Other | Nursing Home 5 | Residence 6 Oth | er: | |
| n of ling Ph After t | ايّا | 27. Manner of Death 28a. Date of Injury | y 281 ar) | . Time of Injury | 28c. Injury at Wor | _ | how injury occurred | | |
| ttend death ctor: | atio | 1 Natural 5 Pending 2 Accident Investigation | | | 1 Yes 2 | No | | | |
| Division of Vital Records, toptial or Attending Physician: The law requir thours after death uneral Director: After this certificate has been sity filled in by the funeral director, page 2 should by | Certification: | 3 Suicide 6 Could not be determined (Specify) | ıry - At home | farm, street, fac | tory, office building, e | etc. 28f. Location (or Town, | | Rural Route Number, City | |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the | Medical C | 29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of exami | | | | | | | |
| Y € ₹ € 8 | Me | 29b. Signature and title of certifier | | | 29c. License number | | 29d. Date signed (M | onth, Day, Year) | |
| | | higher, mos | | | O.C.M.E. | | March 23, 2009 |) | |
| | 1 | 30. Name and address of person who completed cause of dea | • | , | · | | 1 | | |
| | | Ling Li, MD Assistant Medical Examiner | | nn Street, B | altimore, MD 212 | 201 | | | |
| St Regist | ate rar | 31. Date filed (Month, Day, Year) 32. Registrar's | s Signature | back | 1 | | | | |
| DHMH 17 Rev 1/20 | | MARXO COURT CERES | O | RIGINAL | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month S. MARTIN 22:55 M LINDA 03 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Country B Columbia HOWARD COUNTY HUSPITAL Honard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex 1 □ M 2 🛛 F 213-66-2816 55 MD 08/16/1953 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☑Yes 2 ☐ No Laurel Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707 23 Post Office Avenue 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Janet Caroline Woods Vivian Crosby Lanier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23 Post Office Avenue, Laurel, MD 20707 Jay S. Smith / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Dorota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 4. Markha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2-3 months Metastatu Liner can cor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery

/Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

δ

Be Completed

၉

Examine

Physician/Medical

Be Completed by

Certification: To

Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Baltimore, Maryland 21215-0036

| in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | Month Day Year | | | |
|--|--|---|--|--|--|
| Part II. Other significant conditions Hepahto C, | contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unknown | | | |
| Chronii Ob | stoucture Pulminary Dise ask | 24a. Was an autopsy performed? 1□ Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2 ☒ No | | | |
| 25. Was case referred to medical | 26. Place of Death (| Check only one) | | | |
| examiner? 1 | Hospital: 1 Minpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home | ne 5 ☐ Residence 6 ☐ Other (Specify) | | | |
| 27. Manner of Death 1 ↑ At Natural 5 Pending investigation | in (Month, Ďaý Year) Injury Work? 1 ☐ Yes 2 ☐ No | d. Describe how injury occurred | | | |
| 3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined | | f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| 29a. Certifier 1 Certifying P | hysician: To the best of my knowledge, death occurred at the time, date and place, ar iminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | nd due to the cause(s) and manner as stated. It at the time, date and place, and due to the cause(s) | | | |

00058371

, MD21040

29d. Date signed (Month, Day, Year)

03/2012009

State Registrar

5755 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier ()

Cedar Lane, Columbia 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mya Thein, MD,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 5:00 8 M KURBOCK FINHART MARCH 53,5000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEH BURHIE ISOUVAA HUA BACTIMORE-WASHINGTON MEDICAL CENTRA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 F SOUTH CAROLINA Director 9-21-1927 050-28-2540 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State ral", or items 23a or 28a-f shore 1X Yes 2 □ No Funeral Director FAYETTE FAIRBURN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 30213 USA 460 DIX LEE ON DRIVE Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER BALTIMORE CITY SCHOOL -6-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic even VIOLA SMITH ပ ABRAHAM B. SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a TELOCA MURDOCK-SISTRUNK (DAUGHTER) 460 DIX LEE ON DRIVE FAIRBURN, GA 30213 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Dis permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. 1 🖾 Burial Cramation 3 Removal from State 3-25-2009 5 Other (Specify) METRO CREMATORY BALTIMORE, MARYLAND HIBN R^{2.} Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatu of Fundal Service Lice NAHTAMOES D_{\bullet} 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Interval Between Onset and Death Imme late Cause (Final Physician 3 MIFEKC disease or condition resulting in death) AIMOMUBUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown STROKES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1∐Yes 2⊠ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Danisbours by Crowblec 41853000 WAKCH 33, 5000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO DOSE CIANCRECO BOI HOSPITAL DRIVE, GLEN BURNIE, MO 20161 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 25 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items I,4a,2I per dr/fh,2889,03/25/09dhb

Certificate of Death

Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Emily Nichols 2. Date of Death 3. Time of Death Joyner Month. Year **Physician** ,354M door /Medical 4a Facility Name (If not institution, give street and number Collington Community Life 4c. County of Death 4b. City, Town, or Location of Death Examiner Care Mitchellville Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/24/1913 Birthplace (State or Foreign Country)
 NJ 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. Months Hours 1 □ M 2 □ F 95 519-30-5774 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ∏Yes 2 KINo Director MD Prince Georges Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10450 Lottsford Road 20721-USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fil h and Mental F 7 is marked ott Be Elias Joseph Marsh Harriett Lindsley Phelps ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar Kenelm W. Marsh/Nephew 1579 Bobbitt Road Kittrell, NC 27544-Department of Health Important: If item 27 any Injury or other tr altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Mar 19 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee D. Blair Adams per DVR 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed 0501 and burial-trar Due to (or as a consequence P.O. Box 68760, attending physician for/use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No icate has been siç , page 2 should b 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: The performe certificate 2 No 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 □ Yes n 24 hours after death.

e Funeral Director: A sletely filled in by the fu 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

12 State

completely

the within 2 To the

> 31. Date filed (Month, Day, Year) MAR 2 5 2009 Registrar

and title of cortifie

(Check only one)

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Prigt) hills Rd A312 Bowle MS 20716 32. Registrar's Signature

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 3-20-2009

| 09-02300 Melvin Norris | | Please Type | | | | | | | | ible. | 200 | 9 0938 |
|--|------------------------|--|--------------------------------------|-----------------------|-------------|------------------------|----------------|------------------------------------|---|-----------------|------------------------------|---|
| Melvin Noms | | State I- For State | e of Marylan | | | of Healt | | vientai m | | | 200 | 9 0930 |
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Li | ast) | | imodic | O Dodi | | - | 2. Date of Death | g. N o. | | 3. Time of Death |
| Medical Exami | | Melvin Doug | las No: | rris | | | | | Month March 22, 2 | Day 2009 | Year | 1236 hrs |
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| | | Prince George's Hospita | | A = a /lea le | at histhala | Cheve | | If Under 24Hr | Prince George's 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or | | | |
| Funeral Director | | | | Age (In yrs. Ia | ast birthda | Month | | | Min. House Foreign Wash. | | | |
| | | 579-17-9286 1 Usual Residence of Decedent | X M 2 F | 20 | | Yrs. | | | 10/9/1988 Country) DC | | | |
| any | | 10a. State 10b. County | | 10c. City, | Town or L | ocation | | | | | | 10d. Inside City Limits |
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| er dea | 필 | | 1 Yes | 2 X No | . . | Yes 2 | X No. s | enecify: | | Spec | E | lack |
| urs aft tural" | à | 15. Decedent's Education (Specify | or Dates: | completed) | | edent's Usual | | | work done | | of Business/In | dustry |
| 72 hor al Exa | etec | Elementary/Secondary (0-12) | College (1-4 | or 5+) | duri | ng most of wor | rking life. D0 | O NOT use re | tired) | | | |
| 0036 within ene. | Completed | 11 | | | | Nor | | | | | emplo | yed |
| 15-C filed v I Hygi d oth | | 17. Father's Name (First, Middle, La | , | | | | 18. | | e (First, Middle, M | | | ļ |
| 212 Jid be Menta marke | To Be | Melvin Doug 19a. Informant's Name/Relationship | | laney | 19b. M | ailing Address | (Street a | Marc nd Number or | ia Rer | | Norri Town, State, | |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | | Marcia Davis | | er | | | | | shingto | | | |
| e, N. I and Health Health Titem | | 20a. Method of Disposition | | 1 . | | sposition (Nar | | ery, | Date | 20c. Locat | tion - City or | own, State |
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| altin | -1 | 21. re of Fun, a Service ic | | ,,,,,,,, | T | 22. Name and | Address of | | | al M | lortua | ry Inc. |
| @ 55 7 1 | - 11 | Form Marit | سى | | | 411 F | Kenn <u>e</u> | dy St | NW, Wa | shin | gton, | DC 20011 |
| Physician /Medical | | 23 Part I. or er the disease, or confailure. List only one cause on | mplications that cause each line. | sed the death. | . Do not er | iter the mode | of dying, su | ch as cardiac | or respiratory arre | st, shock, c | or heart | Approximate Interval Between Onset and |
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| Mr | Examiner | (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a co | onsequence of | f): | | | | | | | |
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| 30x 68760, death certificate be e e attending physicia for use as the buria | sician/Med | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, ou | | nancy | 1 = 11 | 2 | Fatonia proces | | | te of delivery | Vans. |
| c 68 n certif ending use as | ciar | past 12 months? | 1 Live birt | n it at time of de | ath 5 | Fetal death Other (Spe | | Ectopic pregr | ancy | Mon | ith D | ay Year |
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| cords, law requir has been s | plet | | <u> </u> | | | | | | 24a. Was a autops | sy | | opsy findings available ompletion of cause of |
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| of Vi ing Physic After this Tuneral dir | ို | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date of | patient 2 🗸 | | | 28c. Injury a | | ing Home 5 | Residence | | |
| Division of Vital Records, P.O and or Attending Physician: The law requires that it after death. al Director: After this certificate has been signed by let funeral director, page 2 should be detacted in by the funeral director, page 2 should be detact | io iii | 1 Natural 5 Pending | Menth, D | 009 ear) | 0000 hr | | | 2 V No | Subject shot | | ccarred | |
| iSiC r Atter er dea er dea | icat | 2 Accident Investig | ation 28e Place | of Injury - At he | ome, farm, | street, factory | , office build | ding, etc. | | | | al Route Number, City |
| Div | erti | Suicide 6 Could n 4 Homicide | or be | Sidewalk | | | | | or Town, St 330 Anacostia | ate) Road SE | #D2, Wash | ington, DC |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical Certification: | 29a. Certifier 1 | ician: To the best of | examination a | | | | | | | | |
| To with | Me | 29b. Signature and title of certifier | and manner stat | ed. | | 29 | c. License n | umber | | 29d. Date | signed (Mor | th, Day, Year) |
| | | has his me | | | | | O.C.M. | E. | | March : | 23, 2009 | |
| 2 | ŀ | 30. Name and address of person wh | | | | | | | | | | |
| 4 | | | Medical Exami | | | treet, Balti | more, MI | D 21201 | | | | |
| St Regist | ate | 31. Date filed (Month, Day, Year) NAR 2 5 2005 | 32. Regi | strar's Signatu | ire & | at A | | | | | | |
| DHMH 17 Rev 1/20 | | TOUGH TO GENTLE | | 1 | ORIG | INAI | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 7:32 AMM Bess Grube Nelson March 21, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Renaissance Gardens Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 89 Yrs. 469-09-9872 09/19/1919 ND **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 20904-United States 3160 Gracefield Rd. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 M No Specify Specify: 3

Widowed 4

□ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finance permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, If where any injury or other traumatic event, If where Elementary/Secondary (0-12) College (1-4or 5+) Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Grube Thoen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardythe Jones/Sister 416 Hillsboro Dr. Silver Spring, MD 20902-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mar 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Chesapeake Crematory 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility M0038Z Rapp Funeral & Cremation Services Steple Dohn 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 YEARS ALZHEIMER disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2/ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title 29c. License number

State Registrar MARK

31. Date filed (Month, Day, Year)

NAR 2 5 2009

32. Registrar's Signature

MD

3110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARKHURST

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Records,

of Vital

Division

GRACEFIELD

RD

SILVER SPRING MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1:20P M JOHN CHARLES NORWOOD, JR 20 2009 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Hall 4009 Schroeder Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours 03/06/1956 Director 53 Maryland 215-74-0681 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be marked once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 🙀 No Director Baltimore MD Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4009 Schroeder Avenue Funeral 21128 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No IfYes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo ۾ Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Worker Construction Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ John Charles Norwood, Sr. <u> Clare Magdalene Clemens</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey M. Norwood (wife) 4009 Schroeder Avenue - Perry Hall, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Moreland Memorial Pk. 03/24/2009 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee Al & Sassa 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lypertension **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 152458 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 s autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 052846 March 20,2009 mD

Registrar

DHMH 17 Rev 1/2001

State

MD

Registrar's Signature

30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Doudmen

GOON 31. Date filed (Month, Day, Year) 7602 Belair Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March Physician 20Û9 0425 М Joyce Park /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days Months 1 □ M 2 🔽 F 220-38-8369 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the thadical Evandren, ust be notified at 1 ☐ Yes 2√ No Director MD **Baltimore** Owings Milis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3410 Associated Way, Apt. 320 21117 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: African-American 2 Specify 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Dr. of Dental Surgery Private Practice 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse Hammison Bertha Hedgepeth ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl N. Houze/ Sister 8618 Allenswood Road, Randailstown, MD 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-27-09 Druid Ridge Cemetery Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. Signature of Funeral Service Licensee iondor 9200 LibertyRoad, Randallstown, MD 21133 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mon disease or condition resulting in death) Due to kir as a consequence of): /Medical Examine Lev Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dub to for as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit P.O. Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 1No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie March 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St. Bolts and 2020x

DHMH 17 Rev 1/2001

State Registrar

6701

mo

32. Registrar's Signature

10

31. Date filed (Month, Day, Year) NAR 2 5 2009

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 2:55 P^{M} March 23, 2009 Nancy Gay Slattery /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Days Vear Hours Months 1 □ M 2 🛛 F 78 315-28-0876 10, 1930 Kentucky Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be natified at 1

Yes 2

No Director MD Prince George Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A. 921 Montgomery Street 20707 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 🕏 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant; If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winfred Myers Virginia Pickett 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Davis /daughter 2300 Starcrest Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mary's Cemetery | Mar 27, 09 4 Donation 5 Dother (Specify) Laurel, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 Approximate Interval Between Onset and Death 23a. Part 1. Enter the steadle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he into all ye. List only one cause on each line. Immediate Cause Fina **₽hysicia**n Mensmir disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): 68760 physician Physician/Medical IF FEMALE: Вох 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mont
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □ Yes 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) NOS Medical Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and this of certifier 30. Name and 4ddress of person who completed cause of death (Item 23a) (Type, Print) 1, Charles ST wo 31. Date flet (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:58 AM Naucy skehan Murch 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore. Halber +laspital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/24/1961 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Funeral Days Months Hours 1 □ M 2 🗷 F 154-54-7683 NJ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be ricitived at unk Yes 2 No MD Brooklyn Park 10e. Street and Number 10f. Zip Code Un K 10g. Citizen of What Country? U.S.A. 401 Bon Air Ave Apt. A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 2 Specify: White 3 ☐ Widowed 4 M Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager d 2 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Joseph Sheehan Elmon Papazian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
117 Westover Dr, Cherry Hill, NJ 08034 19a. Informant's Name/Relationship (Type. Print)
Patricia Frisby/Sister item 27 l 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crem. 3/25/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. 21. Signature of Funeral Service Licensee MO 1443 8717 Green Pastures Dr, Towson, MD, 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe a Nemia **Physician** 12 how disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Esophagral valices Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or a conse uence of Examine Alcoholic burial-trans cimhosis requires that the death certificate be execu Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year 5 Other (specify) P.O. cate has been signed by the a page 2 should be detached it 9 Nnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by alcolol 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ! 1 ☐ Yes 2 ☐ No 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Cachilel Timoro 31. Date filed (Month, Day, Year)

Zubiel

29b. Signature and title of certifier

\$2. Registrar's Signature

South

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Hanover

29c. License number

00

street, Baltimor, MD

RES

29d. Date signed (Month, Day, Year)

March 22

2009

State of Maryland / Department of Health and Mental Hygiene Reg. No. ZU Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11:35 PM M March 18 2009 Frank Gerald Startzel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 MM 2 □ F 84 Director 06/28/1924 PA 193-18-7761 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ia or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥Yes 2 No Director Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a Examiner must b United States 21801-Funeral 900 Booth St 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 1943 - 45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify Specify: δ 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Insurance Elementary/Secondary (0-12) College (1-4or 5+) the Agent 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be (Unknown) (Unknown) ပ (Unknown) Startzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 13191 Brookshire Lake Blvd. Ft. Myers, FL 33966-Department of Health Important: If Item 27 any Injury or other tr David Startzel/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Mar 19 4 Nonation 5 ☐ Other (Specify) Bethesda, Maryland 2009 Uniformed Services 21. Signature of Funeral Service License 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Services Lohmann 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HTHEROSCLEMATI /Medical Due to (or as a consequence of) Examiner Securation in a condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe To the Hospital or Attending Physician: 25. Was case referre o medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day 5 ☐ Pending investigation 1 Tes 2 🗆 No 2 Accident filled in by the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Munh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, 82. Registrar's Signature Year) State Registrar

| | | | For State Registrar | State of M | laryland | | artment of H | | d Mental Hy | giene Reg. No. 20 | 09 | 09388 |
|----------------------------|--|--------------------|--|--|-----------------------|-----------------------|--|---|--|---|------------------------------------|---|
| | Physici /Medic | | Decedent's Name (First, Middle, Frances Emogene | , | ı | | | | 2. Date of De | | | 3. Time of Death 6:30 AM M |
| | Examin | | 4a. Facility Name (If not institution, Casey House | | | | 4b. City, Town, o | Derwood | i | 4c. County | | У |
| | Funeral Director | | 5. Social Security Number 220-28-7084 Usual Residence of Decedent | 7. A 1 M 2 | ge (In yrs. las 76 | t birthday) Yrs. | If Under 1 Year Months Days | If Under 24 F Hours M | Irs. 8. Date of Bir in. (Month, Di 11/22 | th ay, Year) 1 1 9 3 2 | 9. Birthp | place (State or Foreign ntry) |
| | Maryland -f show | tor | 10a. State 10b. County MD Montq | omerv | | Town or Lo | | | | | 1 | 0d. Inside City Limits 1 Yes 2 No |
| | n with the | al Director | 10e. Street and Number 324 Seth Place | Omer y | 1100. | | 10f. Zip Code 20850- | _ | | 10g. Citizen of W | | , |
| 036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Exeminar must be nutilled at once. | by Funeral | 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced | 12. Was Decedent Armed Forces' d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | ? | | Was Decedent of H fYes, specify Cuba I□Yes 2⊠No | lispanic Origin? an, Mexican, Pu Specify: | (Specify Yes or No erto Rican, etc.) | Blac | e - Americ k, White, d : Whi | |
| 21215-0036 | within 72 ho jiene. r than "natur if e Medical i | Completed | 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | Education grade completed) College (1-4or | | (Give life. L | dent's Usual Occup kind of work done o DO NOT use retired maker | durina most of v | vorking | 16b. Kind of Business/Industry Own Home | | |
| Maryland 2 | ould be filed Mental Hyg arked other atic event, | To Be C | 17. Father's Name (First, Middle, La | | 1 | | | | lame (First, Middle es M. Lamb | | e) | |
| e, Mar | and 2 sho fealth and fm 27 is m ther traum | | 19a. Informant's Name/Relationship Terry L. Etchiso | | | 3042 | A 57th St | . Brade | Rural Route Numb | ch, FL 3 | 4217 | |
| altimore, | it. Pages 1 rtment of H rtant: If ite njury or ot | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | ecify) | Che | esapea | sition (Name of natory or other place | tory | Mar 25 2009 | Beltsvi | - | Maryland |
| Ba | perm Depa Impo any l | | 21. Signature of Funeral Service In | Lunaun | 00382 | | 933 Gist 2 | ral & Cr Ave. Si | emation Se lver Sprin | ng, Maryl | and 2 | 0910- Approximate |
| | Physician bhysician and the private be executed the physician and the purial-transit the purial-transit the purial-transit the purial-transit the purial-transit the private physician and the physician and the private physician and the physician a | edical Examiner | shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, large larg | a. Due to (or as | 10 | ale | use | | | | | Interval Between Onset and Death |
| O. Box 6 | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a | 2 Fetal de | eath 3 🗆 | Ectopic pregnancy | у | | 23d. Date Mor | e of delive | ery Day Year |
| rds, P. | w requires that been signed b should be deta | <u>م</u> | Part II. Other significant condition | s contributing to death b | out not resultin | ng in the un | derlying cause give | en in Part I. | | obacco use contri ∕es 2 □ No | | e cause of death? |
| ital Reco | The ate h | Be Completed | 25. Was case referred to medical | 1 | | | | 26 Place of D | 24a. Was autor perfo | 2 No 1 | Vere autoprior to coneath? | osy findings available inpletion of cause of 2 No |
| Division of Vital Records, | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it | ertification: To B | examiner? 1 Yes 2 No 27. Mannes of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine | 28a. Date of Inj (Month, Da | ay, Year) | Bb. Time of Injury | 28c. Injun Work | er: 4 ☐ Nursing y at | Home 5 Resid | dence 6 Other | ed | Hospice (Pil |
| _ | Hospital of the state of the st | Medical Ce | (Check only 2 Medical Ex | Physician: To the best | of examination | edge, death | occurred at the ting | ne, date and pla | ace, and due to the | cause(s) and mai | nner as st | tated. |
| | To the within 2 To the comple | Med | 29b. Signature and title of certifler Tocelyne | ko ucuk | ated. | | 29c, License | e number | | 29d. Date signed | (Month, L | Day, Year) |
| • | | | | | | | | Punk 7 | 3000 | MARCH - ME | 24, | 2007 |
| I | Sta Registra | | 31. Date filed (Month, Day, Year) NAK & D 2009 | ATCHGU 1 32. Registr | ar's Signature | West | NIVERSITY | inut, p | 4tci; MOR | e NIN . | sa. · 6 / | |

Head to IME

MARY ELIZABETH SWEENEY

| | | 1 - State of Maryland / Department / Department / Department / Department / Department / Departm | artment of Health and M <i>rtificate of Death</i> | | ne No. 2009 09389 |
|--|------------------|---|--|---|---|
| Physic /Med | | 1. Decedent's Name (First, Middle, Last) MARY ELIZABETH SWEENEY | | 2. Date of Death March 24, | ^{Day} 2009 Year 3. Time of Death 6:45A M |
| Exami | | 4a. Facility Name (If not institution, give street and number) Stella Maris Hospice | 4b. City, Town, or Location of Death Timonium | | 4c. County of Death Baltimore |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M $\frac{1}{2}$ | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth OCT 10, 19 | 9. Birthplace (State or Foreign Country) Maryl and |
| Maryland a-f show | tor | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Baltimore Timonium | ecation | | 10d. Inside City Limits 1 □ Yes 2 ☑ 🚾 |
| th with the 23a or 28a | Funeral Director | 10e. Street and Number 2525 Pot Spring Road | 10f. Zip Code 21093 | - | Citizen of What Country? |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Landcool Event in the Indillied at once. | d by Fune | I N^Never Married 2 Married I 1 Yes AN No I | Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 □Yes 2 XX lo <i>Specify:</i> | cify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc. Specify: White |
| 21215-(within 72 h iene. than "natu | Completed | (Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+) | dent's Usual Occupation kind of work done during most of workin DO NOT use retired) Itive Assistant | g | Kind of Business/Industry hdiocese of Baltimor |
| aryland 2 should be filed and Mental Hygi s marked other umatic event, 1 | To Be C | 17. Father's Name (First, Middle, Last) John Joseph Sweeney Sr | 18. Mother's Name | (First, Middle, Maid e Anderso | en Surname) |
| b, Mar) and 2 shortealth and 1 m 27 is mainer trauma | 0 6 | | ng Address (Street and Number or Bura Beechwood Road Bal | | |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or any injury or other traumatic event, the 14-dical Event proces. | | 14□Donation 5□Other (Specify) New Cathe | dral Cemetery Mar | 27,2009 | Location - City or Town, State Baltimore, Maryland |
| Balti permit. Departi Importe any Inje | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not ent | 6500 York Road Ba | ltimore, | eld Funeral Home Inc Maryland 21212 |
| Physician /Medical Examiner | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL DISEASE Due to (or as a consequence of): | or the mode of dying, oder as cardiac or | respiratory arrest, | Interval Between Onset and Death |
| | Examiner | Sequentially list conditions, if any, leading to immediate cause. First Industrying Cause (Disease or injury | | | |
| 68760, ifficate be executed g physician and as the burial-transit | edical Exar | that initiated events resulting in death) Last C. Due to (or as a consequence of): d | | | |
| O. Box the death cert the attending | Physician/Med | | Ectopic pregnancy Other (specify) | | 23d. Date of delivery Month Day Year |
| Records, P. he law requires that the hear been signed by ge 2 should be deta | by | Part II. Other significant conditions contributing to death but not resulting in the ur | nderlying cause given in Part I. | | o use contribute to the cause of death? 2 No 3 Probably 4X Unknown |
| I Rec The law ate has be | e Completed | 25. Was case referred to medical | | 24a. Was an autopsy performed? 1 □Yes 2 X N | 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |
| | To Be | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien | 26. Place of Death t 3 DOA Other: 4 Nursing Hom | | 6 X]Other (Specify) HOSPICE |
| ding h. After | ation: T | 27. Manner of Death 1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation 28a. Date of Injury (Month, Day, Year) Injury | | 3d. Describe how inju | |
| DIVISION PROPERTY OF Attention 124 hours after deather Funeral Directors letely filled in by the | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streething building, etc. (Specify) | 17 | City or Town, Sta | |
| DIVI To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by | Medical | 29a. Certifier (Check only one Nurse Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or into Practitioner Nurse Practitioner | estigation, in my opinion, death occurred | d at the time, date a | nd place, and due to the cause(s) |
| To with | | 29b. Signature and title of certifier | 29c. License number R149792 | 29d. D | ate signed (Month, Day, Year) |
| | | 30. Name and address of person who completed cause of death (Item 23a) (Type, F | LEA BD ALMONTHM | MD 21002 | '/ |
| Sta Registr | | 31. Date filed (Month, Day, Year) NAR 2 5 2009 31. Registrar's Signature | Also IIIIONIOM, | III ZIUJ | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () 09390 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:04 P M 22 2009 Robert Maurice Smith Jr. March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 12, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Yrs. Director 216-44**-**1336 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f ehov 1 ☐ Yes 2 X No Director Maryland Harford Perryman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1612 Johnson Lane 21130 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 2 ☐XNo Specify: δ 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Engineer Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Maurice Smith Margaret Caroline Conklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2
Department of Health ai
Important: If item 27 is
any Injury or other trau Irma Smith / Wife 1612 Johnson Lane, Perryman, Maryland, 21130 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3-28-09 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one muse on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à certificete has been signirector, page 2 should be Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes : After this certification funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manger of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pendina Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number **D80 36940** who completed cause of death (Item 23a) (Type, Print) HAZFORD MEMORIAL HOSPIONE, 501 SOUTH

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

UNION AVENUE, HAVRE

State of Maryland / Department of Health and Mental Hygiene 09391 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Month Christine Schaller 1:00 PM March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea October 21, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1^{Year}1917 Hours 1 □ M 2 1 F Days 234-32-2094 Director West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examin or must be multical an any injury or other traumatic event, the Medical Examin or must be multical an any injury or other traumatic event, the Medical Examin or must be multical and any injury or other traumatic event. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore Dundalk 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 6526 Colgate Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. 9 Specify 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cable Inspector Western Electric 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Nicolette Rose Missena ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Davis niece 9107 North Point Road, Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 27. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) 2 HOUR /Medical Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IWEEK Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director; 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) usesa RES-000 March 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rowe D.D. 4940 Eastern Avenue Baltimore Theresa 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Jack Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #5 per FH C889 3/25/09 TT
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle 2. Date of Death 3. Time of Death Month **Physician** 715PM 200 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Jast birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs **Funeral** Months Days Hours Min. Director yan d Usual Residence of Decedent death with the Maryland 10b. County Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No **Funeral Director** mor 10f. Zip Code 10g. Citizen of What Country? or items 23a or USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - America Black, White, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Emmires once. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No à Specify. 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of siness/Industr (Give kind of work done during most of working life. DO NOT use retifed) (0-12) College (1-4or 5+) Laborer 's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ဂ္ Tame/Relationship (Type. Route Number, siste BAITO West Baltimore, Method of Disposition 20a. Location -Buriar 2 Cremation 3 Removal from State ☐ Other (Specify) 4 Donation 23a. Part J. Enter the dis hock, or heart tolk hum sate Cause (Final e, or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest **Physician** se or condition ulting in death) /Medical **Examiner** Se quanticity first a redicines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 2 No 1 Yes 2 No 1 □Yes 25. Was case referred to edical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ∏No within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only one) 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3/22/2009 Day Myrtle I. Taylor 11:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death

Sykesville

Days

Months

10f. Zip Code

1 □Yes 2 No

Secretary

21784

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

If Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Ella King

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6097 Oklahoma Road, Sykesville, Maryland 21784

Min

7. Age (In vrs. last birthday)

10c. City, Town or Location

Sykesville

86

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates:

College (1-4or 5+)

Physician /Medical Examiner

Transitions Health Care

10b. County

6097 Oklahoma Road

1 Never Married 2 Married

3 ₩ Widowed 4 □ Divorced

Elementary/Secondary (0-12)

Frances Layman

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Betty T. Evans / Daughter

10

Carroll

15. Decedent's Education (Specify only highest grade completed)

6. Sex

1 □ M 2 🛛 F

5. Social Security Number

217-14-6854

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner man be regular at orca.

Baltimore, Maryland 21215-0036

Funeral Director

Completed by

Be ပ MD

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran attending ph for use as the signed by the a I be detached f certificate has I rector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the

Division of Vital Records, P.O. Box 68760,

20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burian 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 3/25/2009 Elkridge, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Puter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dunemonia sacte disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2.2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2√No Other: Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred # □ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number D43725 Westminister MD 2115

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Carroll

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Specify: White

Federal Government

20c. Location - City or Town, State

23d Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Year

Month

16b. Kind of Business/Industry

USA

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 X No

Maryland

8. Date of Birth (Month, Day, Year) 8/23/1922

18. Mother's Name (First, Middle, Maiden Surname)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

19, Ridge MATHMOUD

31. Date filed (Month, Day, Year) State MAR 2 5 2009 Registrar

2. Registrar's Signature

Roud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 09394 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 2009 Donald Charles Thompson 12 40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F Months Days Hours Min 214-64-9835 Director 54 10-26-1955 Texas Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f short than "natural", or items to rotified at 1 ☐ Yes 2 No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7421 Village Road #15 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 No 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, Ite Ivenical Examina any Injury or other traumatic event, Ite Ivenical Examina once. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ XIo Specify: þ Specify: White 3 ☐ Widowed 4 █ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Supply Industry Purchasing Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine Jaeger Harry Reinhardt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17344 Old Frederick Road, Mt. Airy, MD 21771 Edwin Reinhardt (Brother) 20b. Place of Disposition (Name of complety, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 3-27-2009 4 ☐Donation 5 ☐ Other (Specify) |Princess Anne, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel, P.A. PO Box 195, Sykesville, MD 21784 101314 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Disk to for each consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate performed Division of Vital 2 🗆 No 2 No 1 □ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1∐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne Death Date of Injury (Month, Day, Year) e Hospital or Attending P 124 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on one) the

State Registrar

29b. Signature

Name and

31. Date filed (Month, Day, Year)

d/title of certifier

5

ddress of person who completed cause of death (Item 23a)

Street L

DHMH 17 Rev 1/2001

State

Registrar

% D 2009

| | | | For State Registrar | | State of Ma | | | rtment of F <i>tificate of I</i> | | and Me | | giene Reg. No. | 009 | 09396 |
|---------------------|---|-------------------|--|--------------------------------|--|--------------------------|--------------------|---|----------------------------|-----------------------------|--------------------------------------|-----------------------------|---|---|
| | | | 1. Decedent's Name (/ | First, Middle, Las | et) | - | | | | 2 | . Date of Dea | ıth | | 3. Time of Death |
| | Physici /Medio | | Lemeuble | Toussai | nt | | | • | | | Month March | 21, 2 | 009 Year | 1:10 AM M |
| | Examir | | 4a. Facility Name (If no | ot institution, give | street and number) | | | 4b. City, Town, or | r Location (| of Death | | 4c. Coi | unty of Death | |
| · | | | Casey Hou | | | | | | Derwo | | | | ntgomen | |
| | Funeral Director | | 5. Social Security Num 070-84-76 | 1 | ex 7.Ag M⊠ 2□F | e (In yrs. last birt | thday) . Yrs. | If Under 1 Year Months Days | If Under Hours | Min. 8 | Date of Birtl (Month, Day 03/2 | Year) 5 /1 934 | 9. Birth Cou. 1 Hai | |
| | and w | | Usual Residence of De 10a. State 10 | ecedent Ob. County | | 10c. City, Town | or Loc | cation | | | | | | Od. Inside City Limits |
| | Maryl f sho | ţō | MD | Montgom | erv | German | nto | wn | | | | | | 1 ☐ Yes 2 🔀 No |
| | r 28a | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | | 10g. Citizen | of What Cou | ntry? |
| | h with | | 13059 Oper | n Harth | Way | | | 20874- | - | | | Hait: | i | |
| ဖွ | 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examilyar must be incitified at | Funeral | 11. Marital Status 1 ☐ Never Married | 2 Married | 12. Was Decedent Armed Forces? | | | Vas Decedent of H | | | fy Yes or No- can, etc.) | | Race - Ameri Black, White, | etc. |
| 99 | hours tural", | ed by | 3 ⊠ Widowed 4 □ | Divorced Decedent's Ed | If Yes, Give Year or Dates: | 169 | | □Yes 2⊠No lent's Usual Occup | Specify: | | Ĭ | | ecify: Bla | |
| Maryland 21215-0036 | within 72 ene. than "na | Completed | (Specify Elementary/Seconda | only highest gra | College (1-4or 5 | +) | (Give I life. D | kind of work done of NOT use retired | during mosi | t of working | | _ | uarant | dustry |
| р 5 | filed Hygi | | 17. Father's Name (Fin | st, Middle, Last) | | 1416 | 3 T I I I | cenance | 18. Mothe | r's Name (F | First, Middle, | Maiden Sur | name) | |
| au | should be i and Mental s marked o umatic eve | To Be | | oussaint | | | | | | da Lo | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| ary | shou and M s mar umat | _ | 19a. Informant's Name | e/Relationship (7 | ype. Print) | 19b. | Mailin | g Address (Street | and Numbe | er or Rural F | Route Numbe | r, City or To | wn, State, Zig | Code) |
| ž | and 2 salth a | | Ludwidge T | Coussaint | :/Daughter | 1 . | | 9 Open H | | | | | | |
| Baltimore, | ges 1 g | | 20a. Method of Dispos | | Removal from State | 20b. Place of cemeter | Dispos y, crem | sition (Name of natory or other place | ce) | Date | 9 | 20c. Location | on - City or To | own, State |
| <u>=</u> | it. Par rtmen rtant: njury | | 4 □ Donation 5 | ☐Other (Specify |) | | | leaven Ce | | 3/27/ | 09 | Silve: | r Spri | ng, MD |
| Ba | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic everes. | | 21. Signature of Funer | 1 CX 4 | man | 100382 | F | Name and Addres Rapp Funer 333 Gist A | al & | Cremat | | | yland 2 | 0910- |
| | | | | allure. List only o | lications that caused one cause on each lir | the death. Do n | ot ente | er the mode of dyin | ng, such as | cardiac or r | espiratory arr | est, | | Approximate Interval Between |
| 3 | Physician / /Medical | | Immediate Cause (Fin disease or condition resulting in death) | al | a | L | ine | y Car | ncer | | | | | Onset and Death |
| | Examiner | | | • | Due to (or as | a consequence o | of): | 4 | | | | | 1 | |
| 4 | D .± | iner | Sequentially list conditi if any, leading to imme- | ions, diate | b Due to (or as | a consequence o | of): | | | | | | | |
| | ecute and Ftrans | Examiner | Cause (Disease or inju- that initiated events resulting in death) Last | irv | C | a consequence o | .f). | | | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | | | | d | a consequence o | ·1). | | | | | | | |
| | E 5, 6 | ledical | | | u | | - | | | | | | | |
| O. Box | w requires that the death certific sbeen signed by the aftending p should be detached for use as is | hysician/M | IF FEMALE: 23b. Was decedent pre in the past 12 mo _1 □ Yes 2 □ No 9 □ Unknown | nths? | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal déath | | Ectopic pregnancy Other (specify) | у | | | 23d. | Date of delive Month | ery Day Year |
| ρ, J | ss that gned t | y P | Part II. Other significat | nt conditions co | entributing to death bu | it not resulting in | the un | derlying cause give | en in Part I. | | 23e. Did tol | bacco use c | ontribute to the | ne cause of death? |
| org | require een si ould k | ted | Chronic C |)bstruc | true Julm | anary | <u> </u> | isease | | | 1 □ Y€ | s 2∐No | o 3 Prob | pably 4 🗹 Unknown |
| " | ~ 27 76 | Completed by P | | | | | | | | | 24a. Was a autops perform | ned2 | tb. Were auto prior to co death? 1 □ Yes | psy findings available mpletion of cause of |
| Vital | cian: ertific ector, | Be | 25. Was case referred examiner? | | | | | | 26. Place | of Death (C | Check only on | | / | 2010 |
| 6 | Physi this c | | 1 Yes 2 No | | | nt 2 ER/Out | · | | 4 L Nu | rsing Home | 5 ☐ Reside | ence 6 | Other (Specif | nHospice 1PU |
| ב | ding F | ion | | Pending | 28a. Date of Injur (Month, Day | | ime of ijury | 28c. Injury Work | ? | | I. Describe ho | w injury occ | curred | - 4 |
| UIVISION | Attend death ctor: y the | licat | | investigation Could not be | 28e. Place of Inju | rv - At home, fari | m stre | | Yes 2□N | | Location (St | root and Nu | imbor or Pura | l Route Number, |
| 2 | s after s after al Dire | Certification: To | 4 ☐ Homicide | determined | building, etc | (Specify) | ,,, 0.,0 | or, ractory, emoc | | 201. | City or Town | n, State) | imber or Hura | r Houle Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s | Medical (| 29a. Certifier 1 (Check only one) | Certifying Phy Medical Exam | vsician: To the best of iner: On the basis of and manner sta | examination and | death | occurred at the tin estigation, in my o | ne, date an pinion, dea | d place, and th occurred | d due to the c at the time, d | ause(s) and ate and plac | I manner as s ce, and due to | tated. the cause(s) |
| | To th withir To th comp | Me | 29b. Signature and title | 3 | 10 | | | 29c. License | | 2 | 2 | 9d. Date sig | ned (Month, | Day, Year) |
| | | | Docel | yne K | euchehi | ou; m | D | DOO | 63/ | 40 | | 3- | 23-0 | 9 |
| | | | 30. Name and address Jocelyne | of person who c | ompleted cause of de | eath (Item 23a) (1 | | | 10 | 0 | R. 07 | | him | 7,718 |
| | Stat | е | 31. Date filed (Month, L | Day, Year) | 32. Registra | r's Signature | 1 h | .Unive: | sing ! | recy. | pall | more | - MD | 41410 |
| | Registra | | NAK | S D STITE | prema | A. A | an | | | | | | | |

ath with the Maryland

| 9800 | be filed within 72 hours after dental Hygiene. ed other than "natural", or tems event, the Medical Expriner | by Fune | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced | 12. Was Decedent Ever Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 196 | | 13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No | an, Mexican, Puert | pecify Yes or No o Rican, etc.) | | ce - American Indian, ack, White, etc. fy: Black |
|---------------------------|--|--------------------------------|---|--|----------------------------|--|---|---------------------------------------|-----------------------------------|---|
| 21215-0036 | within 72 hc iene. • than "natul | Completed | 15. Decedent's Education (Specify only highest grant Elementary/Secondary (0-12) | ducation | 16a. | Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired | during most of wor d) | king | | Business/Industry tainment |
| land 21 | should be filed wind Mental Hygier marked other the imatic event, the | To Be Cor | 17. Father's Name (First, Middle, Last, Arthur Takeall | 1 | R | adio Announ | 18. Mother's Nam | ne (First, Middle, Marie Br | | me) |
| , Maryland | nd 2 sho alth and 27 Is me r traume | | 19a. Informant's Name/Relationship (Arthur O. Takeall | | | Mailing Address (Street 5 | | | | |
| Baltimore, | S = = 0 | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specification) | nemoval nom State | | Disposition (Name of crematory or other place) med Service | | Mar 21 2009 | | - City or Town, State |
| Balti | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service Licer | | 382 | 22 Name and Addres Rapp Funes 933 Gist A | ss of Facility ral & Cren | nation Se ver Sprin | rvices | Land 20910- |
| | Physician /Medical Examiner | | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | plications that caused the one cause on each line. a. Due to (or as a column) | FC CA | KER | | | | Approximate Interval Between Onset and Death |
| | | Examiner | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | b Due to (or as a cor | nsequence o | f): | | | | |
| 8760, | eath certificate be executed attending physician and for use as the burial-transit | | that initiated events resulting in death) Last | Due to (or as a cond. | nsequence of | ·): | | | | |
| P.O. Box 68760, | the death certificate be executed y the attending physician and ched for use as the burial-transit | Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | у | | | ate of delivery onth Day Year |
| | Attending Physician: The law requires that the distributions and again. ector: After this certificate has been signed by the by the funeral director, page 2 should be detached by the funeral director, page 2. | ed by Ph | Part II. Other significant conditions of | | | the underlying cause give | | | obacco use con | tribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown |
| ivision of Vital Records, | : The law recate has be page 2 sho | Complet | | | | | | 24a. Was autop | rmed? | Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |
| Vita | Physician: r this certific ral director, I | Be | 25. Was case referred to medical examiner? | Hospital: | | Otho | 26. Place of Deat | | | |
| on of | Attending Phys r death. ector: After this by the funeral di | tification: To | 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day, Yea | 28b. Ti | ury Work | 4 LI Nursing H | ome 5 ☐ Resid | | |
| Divisi | al or Attend s after death I Director: | Certifica | 3 Suicide 6 Could not be determined | | At home, farr pecify) | n, street, factory, office | | 28f. Location (S City or Tow | Street and Numb vn, State) | per or Rural Route Number, |
| | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by | Medical C | 29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam | ysician: To the best of my niner: On the basis of exa- and manner stated. | knowledge, mination and | death occurred at the tin /or investigation, in my o | ne, date and place pinion, death occur | , and due to the rred at the time, | cause(s) and m date and place, | anner as stated. and due to the cause(s) |
| n | To the Common Co | Ž | 29b. Signature and title of certifier | M.D. Pesti | YE I IT | 29c. License | number 35 Z 9013 | | 29d. Date signe | d (Month, Day, Year) |
| 7 |) | | 30. Name and address of person who of | | | GREENE | Street | -BALH | more | MD 2-1201 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) MAR 2 5 2009 | 32. Registrar's S | ignature Jean | Rad | , | | 246 - / | |
| DHI | MH 17 Rev 1/2 | 001 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene200State
Registrar amend 1 per Dr. g890 4/24/09ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jaymia Diane Thompson MAR Year Physician 3:10 P.M. VIANE THOMP 2009 20 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR Baltimore Gi If Under 1 Year If Under 24 Hrs. HUS: 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 20 M Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other treumatic event, the Madical Examiner wast be notified at Baltimore 1 →Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2/225 or Iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ✓ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced ear or Dates "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sum Be it of Health and Mental Lompsun ۵ Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number City or Town, State, Zip Code) 21225 a avu Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 6 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If eny injury or once. Zion 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License 22. Name and Address 701 MC Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYDROCEPHALUS SEVERE Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list or alliers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physicien for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ۵ 1 Tes 2. No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has After this certificete 1 Yes 2 No Physicien: funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Impatient 3□ DOA 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 ⊟Natural 5 Pending 2 No within 24 hours efter death. To the Funeral Director: A 2 Accident investigation 1 Tes filled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cumpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. NEDRATO completed cause of death (Item 23a) (Type/Print) 30. Name and address of person was LAUPEL 300 oultimore. 32, Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 25 2009 Registrar

| | | | For State Registrar | State of Mi | | | icate of t | | ia ivient | aı mygle. Reg. | - / 1111 | 9 09399 |
|--------------------------------|--|-------------------|--|--|-------------------------------------|--------------|--|-------------------|-----------------|---------------------------------------|---------------------------|--|
| | Physici /Medi | | 1. Decedent's Name (First, Middle, | | om AS | | | | | te of Death | Day Yea | |
| | Examir | | 4a. Facility Name (If not institution, SECOUPS | give street and number) | | 4b | BALTIN | r Location of D | | | 4c. County of D | eath |
| | Funeral Director | | 5. Social Security Number 529-70-3340 Usual Residence of Decedent | 197 M OF E | e (In yrs. last birt | | Under 1 Year onths Days | If Under 24 | | te of Birth onth, Day, Ye | ar) 9. 1 48 | Birthplace (State or Foreign Country) |
| | ryland how | _ | 10a. State 10b. County | | 10c. City, Town | | | | | . | | 10d. Inside City Limits |
| | he Ma | ecto | MD NA | | Bal | Ltimo | | | | | | 1 X Yes 2 No |
| | with the | Dir | 10e. Street and Number | ing Aug | | 1 | Of. Zip Code | 1211 | | 10g. | Citizen of What | * |
| | death | Funeral Director | 3512 Greenspr 11. Marital Status | 12. Was Decedent I | Ever in U.S. | 13. Was | Decedent of H s, specify Cuba | | ? (Specify Ye | es or No- | 14. Race - A | merican Indian, |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event and the realthed at once. | Completed by Fu | 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? d 1 X Yes 2 □ 1 If Yes, Give Year or Dates: | No | | | Specify: | uerto Rican, | etc.) | Black, Wi | Black |
| 15-(| n 72 h "'natu edice | lete | 15. Decedent's (Specify only highest | Education grade completed) | 16a. | (Give kind | 's Usual Occup of work done of NOT use retired | durina most of | working f | 16b | . Kind of Busines | ss/Industry |
| 212 | d withi giene. r than | omo | Elementary/Secondary (0-12) 12th grade | College (1-4or 5 na | (i+) | | tenanc | , | | v | arious | Jobs |
| pu | tal Hy d othe | Be C | 17. Father's Name (First, Middle, La | ist) | | | | _ | | | len Surname) | |
| Z Sa | d Men marke | ဥ | Ewing J. Tho | | 1 | | | | | ntgom | - | |
| Ma | nd 2 sl alth an 27 Is r r traui | | 19a. Informant's Name/Relationship Marlene Howar | | | | | | | | y or Town, State | e, Zip Code) Md 21211 |
| ore, | es 1 al of Hea fitem rothe | | 20a. Method of Disposition | - | _, | | n (Name of ry or other place | | Date | | Location - City | |
| <u><u>H</u></u> | . Page tment tant: It jury o | | 1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | LI Removal from State | | | | i | 3/25 | /09 1 | Woodla | vn. Md |
| Baj | permit Depar Impor any in once. | | 21. Signature of Funeral Service Lie | ensee A | 11 man | Marc Marc | Forestone and Address Ch F/H | West | o Po | ltimo | re, Md | SUPORA DESIROR |
| | | | 23a. Part 1. Enter the disease, or consheck, or heart failure. List or | omplications that caused | the death. Do n | | | | | | Le, Mu | Approximate Interval Between |
| 1 | Physician | | Immediate Cause (Final disease or condition | SEPS | 15 | | | | | | | Onset and Death |
| 1 | /Medical Examiner | | resulting in death) | | a consequence o | | C 31 B | | | | | |
| | | ē | Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury | b. Due to (or as | a consequence of | A V | GNA. | F) | | | | |
| | ecuted nd ransit | Examiner | that initiated events | | | | NAU | DISTA | 88 | | | |
| 60, | be exe | | resulting in death) Last | | a consequence o | | | | | | · · | |
| 68760, | rificate be executed ng physician and as the burial-transit | Medical | | d. Myrek | 2161251 | | | | | 74 | | |
| | To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use a completely filled in by the funeral director. | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 🗀 Fetal death | | opic pregnancy ner (specify) | / | | _ | 23d. Date of o | lelivery Day Year |
| rds, P | quires that in signed t | ed by Pi | Part II. Other significant condition: | | | the underl | ying cause give | en in Part I. | 23 | | | to the cause of death? Probably 4 Unknown |
| Division of Vital Records, | ding Physician: The law re n. After this certificate has ber funeral director, page 2 sho | Completed by | DEMENTI; | Å | | | | | _ | a. Was an autopsy performed? Yes 2 🔀 | prior to | autopsy findings available ocompletion of cause of ? |
| /ita | cian: ertifica ector, p | Be | 25. Was case referred to medical examiner? | | | | | 26. Place of | Death (Chec | k only one) | | |
| o | Physic rthis cral dire | ٦. | 1 ☐ Yes 2 ☒ No 27. Manner of Death | Hospital: 1 Inpatie | ent 2 ER/Out | · | DOA Othe | er: 4 Nursir | ng Home 5 | Residence | 6 ☐ Other (S _i | pecify) |
| <u>o</u> | nding ath. r: Afte e fune | ation | 1 Natural 5 ☐ Pending 2 ☐ Accident investigat | (Month, Day | y, Year) | jury | Work | Yes 2 □ No | 28ú. De | scribe now in | jury occurred | |
| Divis | ial or Atte | Certification: To | 3 ☐ Suicide 6 ☐ Could not determine | | ury - At home, fari c. (Specify) | m, street, f | actory, office | | 28f. Loo Cit | cation (Street y or Town, Sta | and Number or ate) | Rural Route Number, |
| | he Hospit in 24 hour he Funera ipletely fille | edical | (Check only 2 Medical Ex | Physician: To the best of caminer: On the basis of and manner sta | f examination and | I/or investi | gation, in my o | pinion, death o | occurred at the | ne time, date a | and place, and d | ue to the cause(s) |
| | Vith Com | Σ | 29b. Signature and title of certifier | Na am 1 a 1 | 14.4.00 | | 29c. License | number | | 29d. [| Date signed (Mo | nth, Day, Year) |
| | | - | 30 Name and address of name | o completed assess of a | eath (Itom 22a) /7 | Type Delet | 2000 | 749 | A-11-7. | 7 | 118/20 | 7 9 |
| | | | JANET VY M | WEH SELI | 1 MD | ype, Print) | BAUT. | mone | 8 1 11 | MD J. | 17 73 | C/ |
| Ì | . Sta Registra | te ar | 29b. Signature, and title of certifier OVL7 U- 30. Name and address of person when the state of the state o | 2009 32. degistra | ar's Signature | par | 2 | | | | | |

| | | | 1 – For State Registrar | State of N | laryland / Dep <i>Ce</i> | artment of F ertificate of | | Mental Hy | /giene Reg. No. | 09 | 09400 |
|---------------------|--|----------------|---|---|--|---|--|---|---------------------------------------|-----------------------|---|
| | Physic | ian | 1. Decedent's Name (First, Middle | e, Last) | | | | 2. Date of De | eath | V | 3. Time of Death |
| | /Medi | | Marva Williams | | | | | March | 20 20 | Year)9 | 10:07 p. M |
| | Exami | | 4a. Facility Name (If not institution | , give street and numbe | r) | 4b. City, Town, o | r Location of Dea | | 4c. County | of Death | 17. |
| 1 | | | Gilchrist Hospic | | | Towson | | | | Baltim | ore |
| | Funeral Director | | 5. Social Security Number | 6. Sex 7. A 1 | nge (In yrs. last birthday 51 Yrs. | Months Days | If Under 24 Hrs Hours Min | | rth aw, Vear) | 9. Birthpla Countr | ce (State or Foreign y) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ |
| | and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 100 | d. Inside City Limits |
| | Mary -f sh | į | MD n/a | a | Ra | ltimore | | | | | 1√2 Yes 2 □ No |
| | r 28a-f show | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Countr | 21 |
| | th with 23a or | <u></u> | 2843 Forest Glen 1 | Pood | | | 21216 | | | | , . |
| | death ms 2 | Funeral | 11. Marital Status | 12. Was Deceden | t Ever in U.S. 13. | Was Decedent of H If Yes, specify Cuba | | Specify Yes or No | o- 14. Rac | e - Americai | n Indian. |
| Maryland 21215-0036 | 72 hours after death with the Maryland natural", or items 23a or 28a-f show Jisel Evanifner must be notified at | þ | 1 ☐ Never Married 2 🔀 Marr 3 ☐ Widowed 4 ☐ Divorced | Armed Forces 1 Tes 27 If Yes, Give Year or Dates |] No | If Yes, specify Cuba 1 □ Yes 2 → No | Specify: | to Rican, etc.) | | k, White, etc | n_American |
| 5-0 | 72 hours "natural"; dicel Eva | etec | 15. Decedent (Specify only highes | 's Education | 16a. Dece | edent's Usual Occup | nation | eleim er | 16b. Kind of Bu | siness/Indu | stry |
| 21 | l within 7 jiene. r than "n | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) life. | DO NOT use retired | during most or wo d) | rking | | | |
| 21 | e filed wi al Hygier other th | ပ္ပြဲ | 12th | | Kea | reptionist | | | Advance | d Radio | ojosa |
| ng | _ 0 = | Be | 17. Father's Name (First, Middle, | Last) | | | 18. Mother's Na | me (First, Middle | , Maiden Surnam | e) | |
| ξ | 2 should be n and Menta is marked raumatic ev | 은 | _ Dennis W. Campbell | | | | | L. Mitch | | | |
| Ma | d2sh than 7 is n traur | | 19a. Informant's Name/Relationsh | | | ng Address (Street | | | | | Code) |
| | s 1 and 2 should of Health and Mer item 27 is marks other traumatic | | Tracee C. Hamlett, | Laughter | | Oving Choi | | Owings Mi | LLS,MD 211 20c. Location - | | - 01-1- |
| Baltimore, | eg <u>≒</u> = i | | t√□ Burial 2 □ Cremation | 3 Removal from State | <i>•</i> | osition (Name of matory or other plac | | | | | n, State |
| Ē | permit. Page Department o Important: If any injury or once. | | 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service I | | Woodlawn Ce | metery | 3-27 | '-09 | _Woodiawn | , MD | |
| Ba | permi Depa Impor any ir | | * Davada | M. all | 10 | 2. Name and Addre | Koad, Kand | alistown. | MD 211.33 | A. of E | Balto. Co. |
| 3 | Physician | | 23a. Part1. Enter the disease, or shock, or heart failure. List of the disease or condition | complications that cause only one cause on each | line. | ter the mode of dyir | 11792 | c or respiratory a | ırrest, | lr. | pproximate nterval Between Onset and Death |
| | /Medical | П | resulting in death) | Due to (or a | s a consequence of): | un con | | | MEATES | | |
| | Examiner | | Sequentially list conditions, | b | | | | | | | |
| | | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | s a consequence of). | | | | | | |
| | tificate be executed ig physician and as the burial-transit | xar | that initiated events resulting in death) Last | C. Due to (or a) | s a consequence of): | | | | | | |
| 68760, | be e sician buria | a E | | 500 to (6) at | a consequence on. | | | | | | |
| 687 | ficate phys s the | edical | | d | | | | | | | |
| Box | eath certi attending for use a | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | 23d Date | e of delivery | |
| Ď. | death e atte d for | Physician/M | in the past 12 months? | 4 Pregnant | | ☐ Ectopic pregnance ☐ Other (specify) | у | | Mor | | |
| P.0 | that the de led by the a detached i | hys | 9 Unknown | 9 ☐ Unknown | | | | | | | |
| S, F | uires that signed I d be det | by P | Part II. Other significant conditio | ns contributing to death | but not resulting in the u | nderlying cause give | en in Part I. | 23e. Did t | obacco use contri | ibute to the | cause of death? |
| ord | w require been si should b | ed | | | | | | 1 🗆 ` | Yes 2 No | 3 ☐ Probab | ly 4 ☐ Unknown |
| Records, | e law re has be je 2 sho | Completed | | | | | | 24a. Was | | Vere autopsy | y findings available |
| E E | ician; The certificate h ector, page | , m | | | | · · · · · · · · · · · · · · · · · · · | | | rmed? d | eath? | letion of cause of □No |
| Vital | ician; Th certificate ector, pag | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of Dea | th (Check only o | | 163 2 | |
| of \ | Physia this o | 힏 | 1☐ Yes 2♥No | | ient 2 ER/Outpatier | nt 3 □ DOA Othe | er: 4 🗆 Nursing H | lome 5 Resid | dence 6 10the | r (Specify) | HOSPICE |
| n c | ding Pt h. After th funeral | ü | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Inj (Month, D | ury 28b. Time o ay, Year) Injury | f 28c. Injury Work | v at | | now injury occurre | | |
| sio | tendi leath. tor; / the fu | cati | 2 ☐ Accident investigation in | ation | | M 1 🗆 | Yes 2□No | | | | |
| Division | ital or Attend its after death al Director; led in by the f | Certification: | 4 Homicide determine | ned 28e. Place of in | jury - At home, farm, str tc. (Specify) | eet, factory, office | | 28f. Location (5 City or Tov | Street and Numbe vn, State) | er or Rural R | oute Number, |
| 0 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | 29a. Certifier 1 Certifying (Check only one) 1 Medical E | Physician: To the best xaminer: On the basis and manner s | of examination and/or in | h occurred at the tin vestigation, in my o | ne, date and place pinion, death occu | e, and due to the irred at the time, | cause(s) and mad date and place, a | nner as state | ed. e cause(s) |
| * | vithi To th | Ž | 29b. Signature and title of cortifier | 2 | | 29c. License | | | 29d. Date signed | | |
| | | | Park | 1)1 | | Do | 4345 | | MARCH 2 | 1,200 | 09 |
| | | | 30. Name and address of person v | ho completed cause of | death (Item 23a) (Type, | Print) CHAPLES | c - r. | 7.000 | CASTIANE | MC 41 | 1 0.201 |
| | | | 31. Date filed (Month, Day, Year) | LOVAN, N | U 05LES N | MATER | DI, 841 | 12704 | 011111111111 | E!MS | HLUY |
| | Sta Registra | | MAR 2.5 2000 | 32. Hegist | nar's Signature | 1 | | | | | |

| | 1 - State Registrar | | | , , , , , , | Ce | artment of ertificate of | Death | | | Reg. No. | 2009 | 9 09401 |
|---|--|--|--|--|--|---|---|----------------------------------|--|---|--|--|
| | 1. Decedent's Name (First, M. | <i>fiddl</i> e, Las | it) | | | - | | | 2. Date of De | | Vaar | 3. Time of Death |
| an cal | Hester | i. | -(1-en | -6 | | | | | Month | Day | Year | M |
| er | 4a. Facility Name (If not instit | | | | | 4b. City, Town, | or Location of | | | 4c. | County of Dea | |
| | worth west | bless | A-6-1 | Can to | | Rennel | 1010 | | | | sacton | |
| | 5. Social Security Number | 6. Se | ex | | s. last birthday |) If Under 1 Year | If Under 2 | M Hre I | 8. Date of Bir | | 9. Bir | rthplace (State or Foreign |
| | 215-40-5938 | 1 | □M 2ØF | | 58 Yrs. | Months Days | Hours | Min. | (Month, Da 9-15-19/ | iy, rear) | | NC |
| | Usual Residence of Deceden | nt | | | | | | | | | | |
| | 10a. State 10b. Co. | unty | | 10c. 0 | City, Town or L | ocation | | | | | | 10d. Inside City Limits |
| Director | MD | Balti | moveo | | Rai | ndallstown | | | | | | 1 □ Yes 2 No |
| ě | 10e. Street and Number | | HIDLE . | | 100 | 10f. Zip Code | | | | 10g. Citiz | zen of What Co | ountry? |
| | 0010 M : : : : : : : : : : : : : : : : : : | - D | ı | | | 2 | 11.33 | | | | USA | |
| runerai | 9812 Marriotsville 11. Marital Status | e ROBC | | edent Ever in | U.S. 13 | Was Decedent of | | nin? (Snec | ify Yes or No | . 1 | 14. Race - Am | erican Indian |
| 3 | 1 □ Never Married 2√ | Married | Armed For 1 ☐ Yes | orces? | | If Yes, specify Cul | ban, Mexican, | , Puerto R | ican, etc.) | | Black, Whit | |
| 2 | 3 ☐ Widowed 4 ☐ Divor | | If Yes, G Year or D | ive ZX | | 1 □Yes 2 □ No | Specify: | | | | Specify: | African-America |
| 3 | 15 Dece | edent's Ed | | | 16a. Dec | edent's Usual Occu | ıpation | | _ | 16b Kir | nd of Business | /Industry |
| Completed | (Specify only hi | ighest grad | de completed) | | i (Giv | e kind of work done DO NOT use retire | durina most | of working | 3 | | imore Ci | • |
| ξl | Elementary/Secondary (0-1 | 12) | College (| 1-4or 5+) | Teac | | , | | | | dic Scho | |
| | 17. Father's Name (First, Mid | idle Last) | 5+ | | 1CXC | F.L. | 18 Mother | r's Name | (First, Middle, | | | DIS |
| De l | | | | | | | | | | | zamamo, | |
| 2 | Urashima Warren | | | | | | | | Barnett | | | |
| | 19a. Informant's Name/Relat Russell Lee Will | | | | | ing Address (Stree | | | | | | Zip Code) |
| | | THIR! | OUSUBILI | | | 2. Marciotsv | THE NO | | | | | |
| | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati | ion 3 □ | Removal from | I | . Place of Disp cemetery, cre | osition (Name of ematory or other pla | ace) | Da | te | 20c. Loc | cation - City or | Town, State |
| | 4 Donation 5 □Othe | | | | st Liber | ty Cenetery | , 13 | 326-09 | | Marr | iotsvill | le, ID |
| 1 | 21. Signature of Funeral Serv | vice Licen: | see | 1.1 | , 2 | 22. Name and Addr | ess of Facility | Wylie | Furera | . Hans | P.A. of | Balto. Co. |
| | Mayac | est. | M.U | UUIC | \cup \cdot | 9200 Libert | yRoad, R | Randai. | lstown, | MD 2 | 1133 | |
| Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Eithe, Underlying Cause (Disease or injury that initiated events | { | Due to | (or as a conse | equence of): | | Fa. (U | . «-e_ | | | | Onset and Death |
| cal Exe | resulting in death) Last | l | Due to | or as a conse | doses equence of): | | | | | | | |
| edical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | | d23c. If yes, ou | itcome of pregi birth 2 □ Fe | nancy | □ Ectopic pregnan | ю | | | 2 | 3d. Date of de Month | Olivery Day Year |
| r iiyəlciai ii iinedicai | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan | | | 23e. Did t | | Month | |
| and in John Market | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown | | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan | | | | obacco us | Month se contribute to | Day Year |
| by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown | | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan | | | 10 | obacco us | Month se contribute to No 3 □ P | Day Year of the cause of death? |
| by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown | | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan | | | 1 🗆 \ | obacco us | Month se contribute to No 3 P 24b. Were an prior to | Day Year o the cause of death? probably 42 Unknown utopsy findings available completion of cause of |
| Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 22 No 9 Unknown Part II. Other significant con | oditions co | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan | | | 1 🗆 \ | obacco us | Month se contribute to No 3 P 24b. Were an prior to death? | Day Year o the cause of death? robably 42 Unknown utopsy findings available completion of cause of |
| e completed by ringsicial medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con | nditions co | d | atcome of preg birth 2 □ Fe gnant at time of nown | nancy tal death 3 f death 5 | □ Ectopic pregnan □ Other (specify) □ underlying cause gi | ven in Part I. | of Death | 1 🗆 \ 24a. Was autop perfo | obacco us yes 2 an an osy rmed? 2 No | Month se contribute to No 3 P 24b. Were an prior to death? | Day Year o the cause of death? robably 42 Unknown utopsy findings available completion of cause of |
| o completed by his production | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to medexaminer? 1 Yes 2 No | nditions co | d | itcome of pregibirth 2 Fe prant at time of nown | nancy tal death 3 f death 5 esulting in the t | □ Ectopic pregnan □ Other (specify) underlying cause gi | 26. Place o | sing Hom | 24a. Was autor perfor 1 Yes | obacco us /es 2 [an obsy rmed? 2 No ne) | Month se contribute te No 3 P 24b. Were an prior to death? 1 Yes Other (Spe | Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of |
| to be completed by ringsicial university | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death | dical | d | itcome of pregibirth 2 Fe prant at time of nown | nancy tal death 3 f death 5 esulting in the t | □ Ectopic pregnan □ Other (specify) underlying cause gi | 26. Place o | sing Hom | 24a. Was autop perfo | obacco us /es 2 [an obsy rmed? 2 No ne) | Month se contribute te No 3 P 24b. Were an prior to death? 1 Yes Other (Spe | Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of |
| to be completed by ritysicial (medical | resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to mederation of Death 1 Natural 5 Peresulting Peresulti | dical dical nding restigation | 23c. If yes, out 1 Live 4 Preg 9 Unknowntributing to d | tcome of preg birth 2 Fe pnant at time of nown | nancy tal death 3 f death 5 esulting in the tall ER/Outpatie 28b, Time 6 | □ Ectopic pregnan □ Other (specify) underlying cause gi | ven in Part I. 26. Place of her: 4 □ Nurs | rsing Hom | 24a. Was autor perfor 1 Yes | obacco us /es 2 [an obsy rmed? 2 No ne) | Month se contribute te No 3 P 24b. Were an prior to death? 1 Yes Other (Spe | Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of |
| to be completed by this steam medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Period | dical Inding | d | itcome of preg birth 2 Fe pnant at time of nown leath but not re | nancy tal death 3 f death 5 esulting in the telephone ER/Outpatie 28b. Time Injury | □ Ectopic pregnan □ Other (specify) underlying cause gi | 26. Place of her: 4 □ Nursury at rk? | rsing Hom 28 | 24a. Was autop performance of the control of the co | obacco us (es 2 [an isy rmed? 2 No ne) dence 6 now injury | Month se contribute te No 3 P 24b. Were an prior to death? 1 Yes Other (Spe occurred | Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of |
| to be completed by this steam medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Peres 2 Accident Inv | dical Inding restigation and not be | d | itcome of preg birth 2 Fe prant at time of nown leath but not re // Inpatient 2 [of Injury nth, Day, Year) | nancy tal death 3 f death 5 esulting in the telephone ER/Outpatie 28b. Time Injury | □ Ectopic pregnan □ Other (specify) underlying cause gi ent 3 □ DOA Other of 28c. Inju MO 1 □ | 26. Place of her: 4 □ Nursury at rk? | rsing Hom 28 | 24a. Was autop period 1 Tyes Check only of e 5 Resided. Describe Note: | obacco us (es 2 [an isy rmed? 2 No ne) dence 6 now injury | Month se contribute te No 3 P 24b. Were an prior to death? 1 Yes Other (Spe occurred | Day Year of the cause of death? robably 40 Unknown utopsy findings available completion of cause of secify) |
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| carear cermicanon: 10 de completed dy ruysicianymedical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Cert | dical and the di | 23c. If yes, out 1 | Inpatient 2[of Injury th, Day, Year) e of Injury - At ing, etc. (Spece | nancy tal death 3 f death 5 esulting in the tale ER/Outpatie 28b. Time tale Injury home, farm, st | □ Ectopic pregnan □ Other (specify) underlying cause gi ent 3 □ DOA Ot of 28c. Inju M 1 □ reet, factory, office | 26. Place of her: 4 \(\text{ Nursury at rk?} \) | rsing Hom 28 lo 28 | 24a. Was autor performed autor | an posy rmed? 2. No ne) dence 6 now injury | Month se contribute to No 3 P 24b. Were an prior to death? 1 Pes Other (Special Control of Number or R) | Day Year o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 2 No ecify) ural Route Number, |
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| Medical Certification: To Be Completed by Physician/Medical Exa | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | nding restigation and the termined retifier | 23c. If yes, out 1 Live 4 Preg 9 Unker ontributing to do ontributi | itcome of preg birth 2 Fe prant at time of nown leath but not re leath but not r | nancy tal death 3 f death 5 esulting in the tale ER/Outpatie 28b. Time of Injury home, farm, st cify) nowledge, deanation and/or in | Ectopic pregnan Other (specify) underlying cause gi ent 3 DOA Ot of 28c. Inju Wo M 1 reet, factory, office th occurred at the envestigation, in my 29c. Licen Print) | 26. Place of her: 4 \(\to \) Nursury at rk? Yes 2 \(\to \) No time, date and opinion, death se number | rsing Hom 28 10 28 d place, at | 24a. Was autoperformed at the time, | obacco us /es 2 an ssy rmed? 22 No ne) dence 6 now injury Street anc vn, State) cause(s) date and | Month se contribute to a contribute to the contr | Day Year of the cause of death? probably 4 Unknown utopsy findings available completion of cause of secify) fural Route Number, us stated. e to the cause(s) |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene, 09402 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Day Year Doris Marie Will March 2009 7:04a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 103 Estelle Court Sykesville Carrol1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 □ XF Months Days Hours 73 Director <u>579-42-2187</u> Aug 2 1935 Washington DC Usual Residence of Decedent with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD Carroll Sykesville Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Estelle Court 21784 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☒No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f ss 1 and 2 should be of Health and Menta item 27 is marked unknown Evelyn Richardson other traumatic ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Will (spouse) 103 Estelle Ct., Sykesville, MD 21784 permit. Pages 1 a
Department of Her
Important: If item
any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 3-24-09 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Harght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nam months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): death certificate be execute physician and s the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p ass 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate 1 □Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. revge tom Blod. Elders burg, mo 4784 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martie Williams, Jr. State of Maryland / Department of Health and Mental Hygiene 2009 09403 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day March 21, 2009 Medical Examiner 2058 hrs Martie Williams Jr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2635 Maisel Street **Baltimore** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY g. Birthplace (State or Foreign Country) Months Davs Hours Min. Director 1 X M 2 F 217-23-5594 Yrs 22 89 20 02 MD Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Baltimore 1 X Yes 2 No MD NA hours after death with the Maryland Director items 23a or 28a-f ust be notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 U.S.A. 2738 Wilkins Ave Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 0 2X No Widowed f Yes. Give Yea 4 Divorced Yes 2X No specify: marked other than "natural", c event, the Medical Examiner Specify: Black <u>ຊ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 Puent of Health and Mental Hygiene.
ant: If item 27 is marked other than "1 or other traumatic event, the Midical E Baltimore, MD 21215-0036 Unemployed 11th grade na Unemployed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jacqueline Thomas Be Martie Williams Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martie Williams Sr.-Father 2738 Wilkins Ave, Baltimore, Md 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 Cremation 3 crematory or other place) Removal from State Department Important: injury or otl 3/27/09 Donation 5 Other Specify: Zion Baltimore, Md Mt. ature of Funeral Service Lice) see 22. Name and Address of Facility
March F/H West 4300 wabash Ave, Baltimore, Md 21215 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED red by the attending physician detached for use as the burial Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live hirth Fetal death 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital director Be examiner? Hospital: Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes Inpatient 2 ٩ No funeral 28a. Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 hours after death uneral Director: / Natural FOUND: Pending Yes 2 V No 2 Mar 21, 2009 2050 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2635 Maisel Street, Baltimore, MD within 24 hours a determined (Specify) Rowhouse 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Afgnature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 22, 2009 46-6 30. Name and address of person who completed cause of death (Item 23a)

Registra DHMH 17 Rev 1/2001

OCME 2006

State

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Laron Locke MD.

31. Date filed (Month, Day, Year

| | | | 1 - State of Mary Registrar | | epartment of l Certificate of | | | ene g. No. 200 | 09404 | | | |
|---------------------|--|----------------|--|--------------------------------|---|--|--|--------------------------------------|---|--|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | 2. Date of Death | | 3. Time of Death | | | |
| | Physici /Medi | | Carroll Edward Warfield | | | | March 20 | , 2009 Ye | 1:01 A M | | | |
| | Examir | ner | 4a. Facility Name (If not institution, give street and number) | | | or Location of Death | | 4c. County of [| Death | | | |
| 100 | Funeral | | 2509 Dulany Street 5. Social Security Number 6. Sex 7. Age (Ir | n yrs. last birth | Baltime day) If Under 1 Year | | 8 Date of Birth | | Dirthologo (Ctata ex Carrier | | | |
| | Director | | 212-40-1050 X M 2 F | 67 Y | Months Days | Hours Min. | 8. Date of Birth (Month, Day, Jan 13. | Year) 1942 M | Birthplace (State or Foreign Country) aryland | | | |
| | and and | | Usual Residence of Decedent 10a. State 10b. County 10 | c. City, Town of | or Location | | | | 10d. Inside City Limits | | | |
| | Maryl f sho | tor | | Baltimo | | | | | 1 □ Yes 2 □ No | | | |
| | h the | Director | 10e. Street and Number | Darcing | 10f. Zip Code | | 10 | g. Citizen of Wha | | | | |
| | 23a c | | 2509 Dulany Street | | 21223 | | US | SA | | | | |
| 9 | permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine rout by northed at once. | Funeral | 11. Marital Status 12. Was Decedent Ever Armed Forces? 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No | in U.S. | | an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | American Indian, Vhite, etc. | | | |
| 21215-0036 | ural", | d by | 3 ☐ Widowed 4 🎖 Divorced If Yes, Give Year or Dates: 195 | | 1 □Yes 2 X No | Specify: | | Specify: | White | | | |
| 15 | in 72 l | plete | 15. Decedent's Education (Specify only highest grade completed) | / // | ecedent's Usual Occup Give kind of work done ife. DO NOT use retire | during most of worki | ng 16 | 6b. Kind of Busine | ess/Industry | | | |
| 212 | filed within Hygiene, other than ' | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | | ck Driver | u) | J | rucking | | | | |
| pu | tal Hy d othe | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | | | | | |
| <u>yla</u> | should be ind Mental marked c umatic eve | ၉ | Carroll Eldridge Warfield | | | Mary Hof | | | | | | |
| Mai | d 2 sh th and 7 is n traun | | 19a. Informant's Name/Relationship (Type. Print) Linda Madera/sister | | Mailing Address (Street | | | | te, Zip Code) | | | |
| re, | s 1 and f Health tem 27 other to | | | | 9 Dulany S isposition (Name of crematory or other place | | _ | D Z1ZZ3 | or Town State | | | |
| E 0 | Pages nent of I ant: If ite | | The second of th | | ciematory or other plac del Cremat | i . | | denton, | | | | |
| Baltimore, Maryland | permit, Departn Importa any Inju | | 21. Signature of Funeral Service Licensee | | GO THOME | SCremation | Service | P.O. I | Box 784 | | | |
| | | - | 23a. Part1. Enter the disease, or complications that caused the | 101251 death. Do not | Beverly L. enter the mode of dvir | Heckrotte | r respiratory arres | larksvil | Lle, MD 21029 Approximate | | | |
| | Physician | | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | | 000 500 | | | | Interval Between Onset and Death | | | |
| | /Medical | | resulting in death) a. Due to (or as a cor | nsequence of). | 1 /4 | ULAL | PFUSI | on | (MUNTL> | | | |
| | Examiner | <u>.</u> | sease or condition sulfing in death) a. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| 13 | nsit | nine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c | nsequence of): | | | | | | | | |
| 1, | execunation and ial-tra | Examiner | that initiated events resulting in death) Last C | nsequence of): | | - | | | | | | |
| 68760, | tificate be executed g physician and as the burial-transit | edical | L d | | | | | | | | | |
| | | Med | IF FEMALE: | | | | | | | | | |
| O. Box | e death certific he attending p ed for use as t | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No | Fetal death | 3 Ectopic pregnanc 5 Other (specify) _ | у | | 23d. Date of Month | delivery Day Year | | | |
| J. | hat th ed by detach | | 9 ☐ Unknown Part II. Other significant conditions contributing to death but not | resulting in th | a underlying course aire | on in David | 220 Did tohor | | e to the cause of death? | | | |
| Vital Records, | w requires that the do been signed by the should be detached | ed by | PULMUNIRT 174 | PERT | ENSION | / | 1 Pyes | | Probably 4 Unknown | | | |
| ဝ၁ | law re as be 2 sho | Completed | - HEART FAILUR | | | | 24a. Was an | 24b. Were | autopsy findings available | | | |
| 工 〒 | sician: The law s certificate has b irector, page 2 sl | Com | | | | | autopsy performed 1 □ Yes 2 □ | death | to completion of cause of 1? 'es 2 12 No | | | |
| VII | Physician: rthis certific ral director, | Be | 25. Was case referred to medical examiner? Hospital: | | Tou- | 26. Place of Death | | | | | | |
| 0 | This ald | <u>ا ي</u> | 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient : 27. Manner of Death 28a. Date of Injury | 2 ER/Outpa | | 4 LI Nursing Hor | ne 5 Residenc | <u></u> | pecify) | | | |
| <u>.</u> | nding ath. : Afte e fune | atio | 1 ☑ Natural 5 ☐ Pending (Month, Day, Yea 2 ☐ Accident investigation | ur) lnju | y Work | yat (? Yes 2□No | 8d. Describe how | injury occurred | | | | |
| DIVISION | r Atter er des rector | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Sp. | At home, farm, | | | 8f. Location (Stree | et and Number or | Rural Route Number, | | | |
| 5 | urs aft urs aft rral DI | | | | | | City or Town, S | | | | | |
| : | lo the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director. | edical | 29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my 2 ☐ Medical Examiner: On the basis of examiner and manner stated. | knowledge, d mination and/o | eath occurred at the tir r investigation, in my o | ne, date and place, a pinion, death occurre | nd due to the caused at the time, date | se(s) and manner and place, and d | r as stated. Jue to the cause(s) | | | |
| | Verth verth com | | 29b. Signature and title of certifier | | 29c. License | number | 29d. | Date signed (Mo | onth, Day, Year) | | | |
| | | - | WY VATER | | 1000 | 35024 | | 3/23/ | 2009 | | | |
| | | | 30. Name and address of person who completed cause of death (| MAD | PAIT | 10044 | (Am. I | И Л . — | NURE MNZA | | | |
| | Stat | е | 31. Date filed (Month, Day, Year) 32. Registrar's Si | ignature | 17/14 | NUNCE | VAME, | MACIIN | MUNCE MUIER | | | |
| | Registra | ır | MAR 2 5 2009 Several S. | park. | | | | | | | | |

| | | | 1 For State Registrar | State of Maryland | | ent of Health and ate of Death | | 2009 | 091.05 |
|------------|--|-------------------|---|---|---|---|--|--|--|
| | Dhusia | | Decedent's Name (First, Middle, Lagrange) | ast) , 7 | | | 2. Date of Death | . No. C. UU J | 3. Time of Death |
| | Physic /Medi | | | aine D. | wal | KeR | March . | 22; 2-009 | 8:22 AM |
| - A | Exami | ner | 4a. Facility Name (If not institution, gi | Se @ 1 32 5 Ho | | y, Town, or Location of Dea | Stown | 4c. County of Death | * - |
| | Funeral | | | Sex 7. Age (In yrs. las | st Birthday) If Und | ler 1 Year If Under 24 Hrs s Days Hours Min | 8. Date of Birth | (ear) 9. Birthpl | lace (State or Foreign |
| | Director | | 217-24-3311 Usual Residence of Decedent | 80 | Yrs. | | June 9 | 1928 Ma | ery and |
| | arylan show | 7 | 10a. State 10b. County | 10c. City, | Town or Location | , | | 10 | Od. Inside City Limits |
| | r 28a-f | irect | 10e. Street and Number | <i>A</i> | 10t. | et more | 100 | . Citizen of What Count | 1 No 2 No |
| | 23a o | ral D | 587 5, 1 | Beech Field | Ave | 21229 | 9 | US | A |
| ' 0 | rs after death with the Marylan I", or Items 23a or 28a-f show Xamir at must be mutilled at | Funeral Director | 11. Marital Status 1 □ Never Married 25 Married | 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2. No | 13. Was Dec If Yes, sp | edent of Hispanic Origin? (Secify Cuban, Mexican, Puer | Specify Yes or No- to Rican, etc.) | 14. Race - America Black, White, e | |
| 21215-0036 | ⊇ ta m | þ | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | 1 □Yes | 2 Specify: | | Specify: | ack |
| 15-(| in 72 hours "natural", edical Eva | Completed | 15. Decedent's E (Specify only highest gr | ade completed) | 16a. Decedent's Us (Give kind of v life. DO NOT | ork done during most of wo | orking 161 | b. Kind of Business/Indi | ustry |
| 212 | ed with /giene er thai | Com | Elementary/Secondary (0-12) | College (1, 4or 5+) | TIE | maker | | Clas | lung |
| Maryland | be id o | Be | 17. Father's Name (First, Middle, Last |) | , | 18. Mother's Na | me (First, Middle, Mai | den Surname) | 11 |
| aryl | d 2 should th and Mer 7 is marke traumatic | 은 | 19a. Informant's Name/Relationship | (Type. Print) | 19b. Mailing Addre | ss (Street and Number or R | ural Route Number. C | ity or Town. State. Zio | Code) |
| | as 1 and 2 of Health of litem 27 is rother tra | | Carolin Lee | - daughter | 6814 12 | Frookmi | LL Rd. 1 | Sacto. N | d. 21215 |
| Baltimore, | | | 20a. Method of Disposition 15 Burial 2 □ Cremation 3 □ | Themoval noni State [/] | ce of Disposition (N netery, crematory of | | | c. Location - City or Tow | vn, State |
| altir | permit. Pages Department of Important; If i any injury or once. | l | 4 ☐ Donation | 10 000 | rusen 1 22. Name | and Address of Facility | - | iticton | es, mD. |
| 8 | 8 3 E 8 8 | | Smy (M | ent | Gar | y P. Mare | hFitt. F | Sacto, " | 1.21229 |
| | DI!! | | 23a. Part 1. Eprey the disease, or com shock, or heart failure. List only Immediate cause (Final | one cause on each line. | | | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | a. Ath rosele Due to (or as a consequer | | Tornocular [| iseast. | | |
| | Examiner | <u>.</u> | Sequentially list conditions, | b | | | | | |
| H | executed n and al-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequer | 105 of). | | | | |
| 30, | cate be executed physician and the burial-transit | I Exa | resulting in death) Last | c Due to (or as a consequen | nce of): | | - " | | |
| 68760, | | edical | | _d | - | | | | |
| Box (| leath certifi attending p for use as | an/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnancy | | | | 23d. Date of delivery | v |
| O. B | he dea the att | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4 ☐ Pregnant at time of deal | | pregnancy specify) | | Month D | Day Year |
| σ. | ires that the de signed by the a d be detached f | by Ph | Part II. Other significant conditions of | ontributing to death but not resulting | ng in the underlying | cause given in Part I. | 23e. Did tobaco | co use contribute to the | cause of death? |
| Records, | w requires been sig should be | ted b | | | | | 1 ☐ Yes | 2 No 3 Probal | bly 4 4 Unknown |
| Rec | has be je 2 sh | Completed | | | | | 24a. Was an autopsy | prior to comp | sy findings available pletion of cause of |
| Ital | nysician: The nis certificate h director, page | | 25. Was case referred to medical | | | OC Bloom of Day | performed | | 2 □No |
| of Vital | hysici this cer al direct | To Be | examiner? 1 ☐ Yes 2 ☐₩o | Hospital: 1 ☐ Inpatient 2 ☐ ER | /Outpatient 3 □ □ | | th <i>(Check only one)</i> Iome 5 ☐ Residence | 6 Nother (Specify) | tient hospica |
| ono | ding Ph h. After th funeral | tion: | 27. Man of Death Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day, Year) | Bb. Time of Injury M | 28c. Injury at Work? | 28d. Describe how in | | |
| Division | Attendi er death. ector: A by the fu | Certification: To | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | | | 1 □Yes 2 □No y, office | 28f. Location (Street | and Number or Rural F | Route Number. |
| ō | oital or urs afte eral Dii | | | | | | City or Town, St | ate) | 4 |
| Ď | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical | 29a. Certifier 1 ☐ ¢ ertifying Ph (Check only one) 2 ☐ Medical Exam | ysician: To the best of my knowle niner: On the basis of examination and manner stated. | dge, death occurre and/or investigation | d at the time, date and place n, in my opinion, death occu | e, and due to the cause arred at the time, date | e(s) and manner as star and place, and due to the | ted. he cause(s) |
| | To th withir Comp | Me | 29b. Signature and title of certifier | 0.4.0 | 1 | c. License number | 29d. | Date signed (Month, Da | ay, Year) |
| | | - | > MSkaj upahu | | | 00057465 | | 3/22/0 | 9. |
| | | | 30. Name and address of person who on S. Rajapakse, M. | completed cause of death (Item 23 1D 25 Main St - 82. Registrar's Signature | (Type, Print) | 200, Reister | whown n | 1D. 21136 | |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signature | had I | | / | | |
| | Registra | ell . | MAR 2 5 2009 | person p. | gara | | | | |

| | | | 1 - For State of Maryland / | | artment o | | nd Mental H | ygiene Reg. No. | 009 | 09406 |
|--------------------------------|---|----------------|--|--------------------------------|---|--------------------------------------|---|----------------------------|---|---|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Louise Anna Aikins | | | | 2. Date of D Month March | | 009 Year | 3. Time of Death 9:10P. M |
|) | Examir | | 4a. Facility Name (If not institution, give street and number) Sligo Creek Nursing and Rehabilitation Cer 5. Social Security Number 6. Sex 7. Age (In yrs. last b. | | | | Death | 4c. (| County of Death Montgon | |
| L | Funeral Director | | 146-01-1435 Usual Residence of Decedent | Yrs. | Months Da | | Min. Sept. | 19,19 | 07 New | place (State or Foreign http:) Jersey |
| | Maryland a-f show | tor | 10a. State10b. County10c. City, TownMarylandMontgomeryTakom | | | | | | 1 | 0d. Inside City Limits 1X1Yes 2 □ No |
| | th with the 23s or 28 | al Director | 10e. Street and Number 7525 Carroll Avenue | | 10f. Zip Coo 20912 | | x | _ | ten of What Cour ted Stat | • |
| 900 | filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or items 23e or 28e-f show int, the Modical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Was Decedent f Yes, specify O | | in? (Specify Yes or N Puerto Rican, etc.) | | 4. Race - Americ Black, White, Specify: Whi | etc. |
| Baltimore, Maryland 21215-0036 | filed within 72 ho Hygiene. ther than "netur int, II's Madical | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give life. L | dent's Usual Ockind of work do DO NOT use re | ne during most tired) | of working | | eral Gov | |
| yland | ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than or other treumetic event, If a M | To Be | 17. Father's Name (First, Middle, Last) Səbəstiən Wiedemer | | | 18. Mother | s Name <i>(First, Middle</i> Pret Bade: | | Sumame) | |
| , Mar | 1 and 2 sho Health and Iem 27 is m | | | | | | or Rural Route Number Farmingto | | | ^{Code)} 48334 |
| imore | permit. Pages ta Department of Heis Importent: If item any njury or othe | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | of Dispositry, cren POLI | sition (Name of natory or other) tan Cre | place) emetory | 3/9/2009 | | ation - City or To xəndriə, | wn, State Virginia |
| Ball | permit. Depart Import any inj | | 21. Signature of Funeral Service Licensee Nambel VB engerant | Dc 44 | name and Ad na Id V 100 Powo | dress of Facility Borgwaller Mill | rdt Funer Road Bel | əl Hor tsvil | ne, PA le, Mary | land20705 |
| | Pnysician /Medical | | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a | əthy | | | ardiac or respiratory | arrest, | 5 | Approximate Interval Between Onset and Death MONTHS |
| 8760, | death certificate be executed e attending physician and of for use as the burial-transit | dical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary An Due to (or as a consequence c. Due to (or as a consequence c. | rter | y Disea | ese | | | 1 | yeer |
| .O. Box 6 | death certif e attending od for use as | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | | Ectopic pregna | | | 23 | 3d. Date of delive Month | n y Day Year |
| Д. | The law requires that the ate has been signed by th bage 2 should be detache | þ | Part II. Other significant conditions contributing to death but not resulting in Chronic Obstructive Lung Disease | n the un | nderlying cause | given in Part I. | | tobacco us | | e cause of death? |
| al Reco | | Completed | | | | | | | prior to cor death? | osy findings available npletion of cause of |
| Division of Vital Records, | Phys | cation; To Be | 1 ÅNatural 5 □ Pending (Month, Day Year) 2 □ Accident investigation | utpatient Time of Injury | 28c. Ir | Oals | of Death Check onlining Home 5 Res 28d. Describe | idence 6 | | () |
| <u>XX</u> | or Al | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify) | ırm, stre | eet, factory, offic | СӨ | | (Street and wn, State) | Number or Rura. | l Route Number, |
| | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune | Medical | 29a. Certifier (Check only one) Medical Examiner: On the basis of examination an and manner stated. | e, death | estigation, in m | y opinion, death | place, and due to the occurred at the time, | cause(s) a , date and p | and manner as st place, and due to | ated. the cause(s) |
| 4 | with To | 2 | 29b. Signature and after of certifier | | | ense number 8656 | | | signed (Month, leb 9, 20 | |
| | | | 30. Name of a less of person who completed cause of death (Item 23a) Ravi Passi, M.D. 15225 Shady Grove | (Type, Fo | erint) ad,#208 | Rockvi | lle, Maryl | land 2 | 20850 | |
| 8 | Sta Registr | 7000 | MAR 1 0 2009 Registrar's Signature | par | ري | | | | | |

| | | | 1 - For State Registrar | State of Ma | aryland / [| Department <i>Certificate</i> | of H | ealth and M Death | | giene Reg. No. | 2009 | 09407 |
|---------------------------------------|---|-----------------|--|--|-----------------------------|---|-----------------------|--|--|-------------------------|---------------------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, L | .ast) | | | | | 2. Date of De Month | ath Day | Year | 3. Time of Death |
| | /Medic | | Gilda | Amelio | | | | | March | | 2009 | 11:15 a ^M |
| H. | Examin | er | 4a. Facility Name (If not institution, g | · · | | 4b. City, T | own, or | Location of Death | | | County of Death | |
| | | | Friends Nursing Hom 5. Social Security Number 6. | | e (In yrs. last bir | | dy Sp | oring If Under 24 Hrs. | 8 Date of Birl | | bntgomery | loop (State on Fourier |
| | Funeral Director | | 215–20–5007 Usual Residence of Decedent | 1 □ M 2 💢 F | | Yrs. Months | Days | Hours Min. | 8. Date of Bird (Month, Da Dec. 8, | y, Year) 1917 | Italy | lace (State or Foreign try) |
| | land ow It | | 10a. State 10b. County | | 10c. City, Town | n or Location | | | | | 1 | 0d. Inside City Limits |
| | Mary I-f sh fied a | tor | MD Mont | gomery | S | ilver Sprir | ng | | | | | 1 □Yes 2XXNo |
| | or 28g | Director | 10e. Street and Number | | | 10f. Zip (| Code | | | 10g. Citiz | zen of What Coun | try? |
| | ith will | la [| 10010 Grayson Aven | ue | | | 2090 | | | | USA | |
| | tems termi | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | | 13. Was Decede If Yes, speci | ent of Hi fy Cuba | spanic Origin? (Sp n, Mexican, Puerto | ecify Yes or No Rican, etc.) | | 14. Race - Americ Black, White, | |
| 020 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I frem 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | þ | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 XX If Yes, Give Year or Dates: | lo | 1 □ Yes 2 | | Specify: | | | Specify: Wh | ite |
| 'n | 72 h "natu dical | etec | 15. Decedent's (Specify only highest g | Education rade completed) | 16a. | Decedent's Usual (Give kind of work | Occupa done d | ation luring most of work.) | ing | 16b. Kir | nd of Business/Inc | dustry |
| 7 | within ene. than ' e Me | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | +) | Homemaker | |) | | Own | n Home | |
| 7 | Hygie Hygie Ither i | | 17. Father's Name (First, Middle, Las | st) | | | | 18. Mother's Name | e (First, Middle, | Maiden | Surname) | |
| 0 | ld be lental ked c | To Be | Eugenio Serra | | | | | | DeMiche | | , | |
| | shou and M s mar umat | - | 19a. Informant's Name/Relationship | (Type. Print) | 19b | . Mailing Address (| Street a | and Number or Run | | | r Town, State, Zip | Code) |
| 2 | and 2 ealth an 27 li | | Carmela A. Cowgill | / Daughter | 14 | 1309 Shoreh | am D | rive, Silve | r Spring | MD 2 | 20905 | |
| ב ב | of He | | 20a. Method of Disposition 1 Durial 2 Cremation 3 | ☐Removal from State | 120b. Place of | Disposition (Name ry, crematory or oth | e ot | e) | Date | 20c. Lo | cation - City or To | * |
| | tment tant: tant: | | 4 □ Donation 5 XXOther (Spec | city) Entombment | Gate of | Heaven Ce | | Ly | 12, 2009 | Silv | ver Spring, | , MD |
| ם ם | permit Depar Impor any In once, | | 21. Signature of Funeral Service Lic | ensee | | 22. Name and Francis | J. C | olling Fine | ral Home | Inc. | | |
| | 20200 | | 23a Part1 Poter the disease or co | mplications that caused | the death. Do r | JUU UNIV | ersı | ty Blvd. We | st, Silve | er Spi | ring, MD 20 | |
| | lhi.i | 6 " | 23a. Part1. Enter the disease, or co shock, of heart failure. List on Immediate Cause (Final | | | iot ontor are mode | Or dying | g, such as cardiac c | or respiratory at | rest, | | Approximate Interval Between Onset and Death |
| | hysician /Medical | | disease or condition resulting in death) | a. Cardiac | Arrest a consequence of | of). | | | | | | |
| | Examiner | | | Diabete | · | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | Due to (or as | a consequence | of): | | | | | | |
| | ecute and trans | tami | Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | | |
| 0000 | cian s | E E | Todain, 200 | Due to (or as a | a consequence o | or): | | | | | | |
| 00 | physicate physicate | edical Examiner | | d | | | | | | | | |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | nding use a | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | | , | 3d. Date of delive | D/ |
| | death e atte | icia | in the past 12 months? | 1∐Live birth 4∐Pregnant at | | 3 ☐ Ectopic pre 5 ☐ Other (spe | | | | | | Day Year |
|) | by the | Physician/M | 9 ☐ Unknown | 9□Unknown | | | | | | | | |
| 'n. | gned be de | ру Р | Part II. Other significant conditions | contributing to death bu | t not resulting in | the underlying cau | use give | n in Part I. | 23e. Did to | obacco us | se contribute to th | e cause of death? |
| 50103, | equir sen si ould I | | | | | | | | 1 🗆 \ | ∕es 2 X | XNo 3 ☐ Prob | ably 4 Unknown |
| ַ נ | as be | Completed | Hypertension | | | , | | | 24a. Was autop | SV | | osy findings available |
| - i | ding Physician: The n. After this certificate he funeral director, page | Co | Breast Tumors | | | | | | 1 Yes | rmed? 2 XX No | death? 1 🗌 Yes | 2□ No |
| <u> </u> | siciar certif rector | Be | 25. Was case referred to medical examiner? | Hospital: | | | Othe | 26. Place of Death | | | | |
| 5 2 | r this | : To | 1 ☐ Yes 2 ☐ Your 1 ☐ Yes 2 ☐ | 28a. Date of Injur | y 28b. T | tpatient 3 DOA | c. Injury Work | 4A A Nursing Ho | me 5 □ Resid 28d. Describe h | | ☐Other (Specify |) |
| 5 | naing th. r: Afte e fune | atior | 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) Ir | njury M | | ? ′es 2 ☐ No | | ,, | | |
| 2 | er des recto by th | Certification: | 3 Suicide 6 Could not 4 Homicide determine | be 28e. Place of inju | ry - At home, far | rm, street, factory, | office | | 28f. Location (S City or Ton | Street and | Number or Rurai | Route Number, |
| 5 | rs after all Di | Cert | | | | | | | | | | |
| 17 | To the hospital or Attending Priystcian: The law requires that the death certificate be executed within 24 hospital state death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical | 29a. Certifier 1 CertifyIng F (Check only one) 1 Medical Example (Check only one) | Physician: To the best of aminer: On the basis of and manner sta | examination and | , death occurred a d/or investigation, i | t the tim in my op | e, date and place, pinion, death occurr | and due to the red at the time, | cause(s) date and | and manner as st place, and due to | ated. the cause(s) |
| | withi To ti | M | 29b. Signature and title of certifier | . | | | | number | | 29d. Date | signed (Month, L | Day, Year) |
| 1 | 0 | | Made | all 1 | low | 40 | 04 | 0 600 8 | 9 | 3 | 19/00 | |
| | ` | | 30. Name and address of person who | | | | | | | | | |
| | | | Ramani Bhimavara 31. Date filed (Month, Day, Year) | | 13975 Cont r's Signature | necticut Av | re. S | uite #202, | Silver S | oring, | MD 20906 | <u>-</u> - |
| | Sta Registr | | MAR 11 20 | | _ | | | | | | | |
| OHM | H 17 Rev 1/20 | - | 11111 I I ZU | 09 Senera | p. 19 | arked | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend items 10a-f, 19b per inf g890 4-1-09 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last, March Day Year Physician 10:51A M 2009 ittingham aira /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Yea AUG. 23, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Year) Months 1 X M 2 🗆 F 77 WISCONSIN 222-22-4576 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Wilmington TDAPPE New Castle ĎΕ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 322 Snuff Mill Rd. 10f. Zip-Code 19807 31450 KATES POINT ROAD $\frac{21673}{}$ USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify þ Specify: WHITE 3 Widowed 4 Divorced ed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Complet Elementary/Secondary (0-12) 12 College (1-4 or 5+) INVESTMENT BROKER FAMILY INVESTMENTS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS E. BRITTINGHAM, JR. MARGARET CUMMINS ၉ 19b Mailing Address (Street and Number of Gural Route Number, City of Jown, State Zip Code)
322 Snuff Mill Rd. Wilmington, DE. 19807
31450 KATES POINT ROAD, TRAPPE, MD 21673 19a. Informant's Name/Relationship (Type. Print) ROBERTA A. BRITTINGHAM/ WIFE 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State CHESAPEAKE CREMATORY: 3-4-2009 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 C.F.S.P. Ostraisla Joseph Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intra cranial nemorrinage disease or condition resulting in death) Due to (or as a consequence of) pertungor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2**X** No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA မ 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manger of Death Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident
3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one and manner stated.

or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Box 68760, Division of Vital Records, P.O. ģ this Director: / within 24 hours aft

To the Funeral DI

completely filled in Hospital

Funeral

Director

28a-f show

ö ems 23a or must be r

ral", or items 2 Examiner mus

"natural",

ntal Hygiene. ed other than ' event, the Me

27 is marked of traumatic even

27 other 1

permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

Physician

/Medical

Examiner

the Medical

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

notified at

725 6+VA

-, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Date signed (Month, Day, Year) RES-000

MO PAD Lee

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year) MAR 0 6 2009

29b. Signature and title of certifier

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, 19409 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** THOMAS MATTHEWS BARTLETT Day 2009 rear MARCH 4 4:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 27594 WAKEFIELD LANE EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1**X** M 2□ F Months Days Hours 83 Director 215-20-4627 JUNE 13, 1925 MARYLAND Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director MD TALBOT EASTON 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 27594 WAKEFIELD LANE 21601 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. 10 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ş 1 ☐ Yes 2 No Specify. WHITE 3 Widowed 4 Divorced Specify: "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER FENCING COMPANY 7 is marked other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK R. BARTLETT ည DOROTHY GOLDSBOROUGH of Health and Nitem 27 is mai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JEANINE B. BARTLETT/ WIFE 27594 WAKFIELD LANE, EASTON, MD 21601 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any Injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3-5-2009 CHESAPEAKE CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Joseph CF.S.P. (strough. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** enic years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year ☐ Pregnant at time of death 5 Other (specify) hed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy certificate 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this filled in by the funeral di this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1. Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 2 Accident 1 ☐Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDTVA CAROLYN R. HELMLY, M.D., 508 IDLEWILD AVENUE, EASTON, MD 21601 31. Date filed (Month, Day, Year 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 7, 10:40 PM Maurine Janet Bess 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Gaithersburg Montgomery Wilson Health Care Center 8. Date of Birth (Month, Day, Year) 09/01/1913 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Days Hours Months 1 □ M 2 🛣 F 95 Indiana 306-48-0304 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 301 Russell Avenue #450 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: Specify: Specify: White 3 → Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elma Gilliom Charles Laisure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jane E. Glinka (Daughter) 4019 Great Harvest Court, Dumfries, VA 22025 Date 09, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan 20c. Location - City or Town, State 20a. Method of Disposition March 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia 2009 4 Donation 5 Other (Specify)≠ Crematory 22. Name and Address of Facility DeVol Funeral Home, 21. Sign ture of Funeral Service Line nsee Approximate Interval Between Priset and Death 10 E. Deer Park Drive, Gaithersburg, MD 20877 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leath?

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expringer must be notified at

Baltimore, Maryland 21215-0036

signed by the attending physician and be detached for use as the burial-transit e Hospital or Attending Physician: The law requires that the death certificate be execu 24 hours after death.
E24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-tra letely filled in by the funeral director, page 2 should be detached for use as the burial-tra

Division of Vital Records, P.O. Box 68760

Examiner by Physician/Medical Be Completed

Certification: To

Medical

29b. Signature and title of certifier

1 SeRaprita

| Immediate 4 are final disease or condition | Adult failure to turn | 1 | 3 nest and Death |
|--|---|--|---|
| resulting in death) | Due to (or as a con de uence of): | | |
| Se wentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | b. Biliany curletons Due to (u) as a consequence of): | | |
| that initiated events resulting in death) Last | c | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions co | ontributing to death but not resulting in the underlying cause given in Part I. | 1 | o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown |
| | iace, Topathypoidson | 24a. Was an autopsy | 24b. Were autopsy findings available prior to completion of cause of death? |
| Ostevarthe | etes Domentea | performed? 1 ☐ Yes 2 ☐ | |
| 25. Was case referred to medical examiner? | 26. Place of Dea | ath (Check only one) | |
| 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing H | lome 5 ☐ Residence | 6 ☐ Other (Specify) |
| 27. Manner of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation | | 28d. Describe how inj | ury occurred |
| 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, te) |
| 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam | ysician: To the best of my knowledge, death occurred at the time, date and place siner: On the basis of examination and/or investigation, in my opinion, death occurred manner stated. | e, and due to the cause urred at the time, date a | e(s) and manner as stated. and place, and due to the cause(s) |

Registrar

State

completely within 2 To the the

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month Physician March 4, 9:45 P M Orhan Baycu /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Potomac Valley Nursing and Wellness Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 12/15/1920 Birthplace (State or Foreign Country) **Funeral** Days Hours 88 Turkey 389-40-3336 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, If a Manical Examinar must be notified at Rockville MD Montgomery 1 X Yes 2 □ No 72 hours after death with the Man Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15101 Columbine Way 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forceş? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked offth any livry or other traumatic event, obes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nafiz Baycu Rebia Arif ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hale Sofia Schatz - Daughter 8 Goodwin Lexington MA 02420 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 X Removal from State National Crematory 3/12/09 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 21. Signature of Funeral Service Licensee MO1163 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Hypertension **Physician** /Medical Due to (or as a consequence of): Examiner Chronic Renal Insufficiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Hospital or Attending Physician: The law requires that the death certificate be executed Examir Congestive Heart Failure sician and burial-tran Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760. Bilater Pleural Effusion Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) ☐Yes 2☐No ned by the a 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pneumonia 1 ☐ Yes 2 ☐XNo 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an Hypertension has autopsy performe certificate 1 □Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and itle of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ahmed Heshmat, 10110 Molecular Drive, Rockville, Maryland 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 11

Baltimore, Maryland 21215-0036 **Physician** /Medical

burlal-tran Box 68760, P.O. Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 6:04 P M BALKCUM MARCH 2009 JONATHAN 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F Director 28,1957 WASH. D.C. 214-72-3456 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at once. 1 X Yes 2 □ No Directo PRINCE GEORGES FORESTVILLE MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7507 MARION ST. 20747 U.S.A. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No Specify. <u>۾</u> Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PARTS DRIVER HERB GORDON AUTO 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ HERBERT RAE BALKCUM JUNE MARY PEARSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALKCUM/MOTHER 7507 MARION ST., FORESTVILLE, JANE MARY MD. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3--10--2009 CHAMBERS CREMATORY RIVERDALE, MD. 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 21. Signature of Funeral Service Licensee M00091 5801 CLEVELAND AVE. RIVERDALE, MD. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 5+ Immediate Cause (Final 180 disease or condition resulting in death) Due to (or as a consequence of): Examiner 1 4 70 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 1 □Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 03/09/09 D0064055 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS RD., CLINTON, MD. 20735 McDONALD, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 11 2009

32. Registrar's Signature

| | | | | State of M | arvland | / Dena | rtment of H | lealth and N | Mental Hvo | niene | |
|-------------------|---|---------------------|---|--|--|------------------------------|---|--|--|--|--|
| | | - | For State | State of M | ai yiaiia | | tificate of | | | Reg. No. 2 1 1 | 9 091.13 |
| | | | Registrar 1. Decedent's Name (First, Middle | e. Last) | | | | | 2. Date of Dea | th , , | 3. Time of Death |
| | Physicia /Medic | al . | Randall Donald | Oscar Fitz | | Bris | | | March | | 9 0550 1 |
| | Examin | er | 4a. Facility Name (If not institution Northwest Hosp | | 1 | | 4b. City, Town, o Randa1 | Location of Death | 1 | 4c. County of De Baltir | |
| | Funeral Director | | 5. Social Security Number 219–46–3613 | 6. Sex 1 X M 2 ☐ F | je (In yrs. la: 58 | st birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birtl (Month, Day 07/19/1 | 9. B 950 | rthplace (State or Foreign Country) MD |
| | pu. × | | Usual Residence of Decedent 10a. State 10b. County | | 10c, City. | Town or Lo | cation | | | | 10d. Inside City Limits |
| | a-f shov | ctor | MD Balti | more | - | 1timo | re | | | | 1 □Yes 2XiNo |
| | with the 3a or 28 | I Dire | 10e. Street and Number 1608 Cantwell | Road, Apt. | C | | 10f. Zip Code 21244 | | | 10g. Citizen of What (US | Country? |
| 30 | be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, it is "sected Exercine must be neithed. | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🖾 Divorced | 12. Was Decedent Armed Forces' ied 1 ∐Yes 2 ☑ If Yes, Give Ye ar or Dates: | ? | | Was Decedent of H f Yes, specify Cuba l □Yes 2 ☑ No | lispanic Origin? (S an, Mexican, Puerto Specify: | pecify Yes or No- o Rican, etc.) | 14. Race - An Black, Wh Specify: | nerican Indian, ite, etc. Balck |
| Ş | tura cal E | ted | 15. Deceden | t's Education | | 16a. Dece | dent's Usual Occup | pation | leina | 16b. Kind of Busines | s/Industry |
| 9500-6121 | within 72 ene. than "na | Completed | (Specify only higher Elementary/Secondary (0-12) 12 | College (1-4or | 5+) | | ssembler | during most of wordd) | King | Manufa | cturing |
| yland 2 | be filed ital Hyg id other event, I | Be | 17. Father's Name (First, Middle, Oscar Donald E | · | | | | 18. Mother's Nan Cathe | ne (First, Middle, erine Mai | Maiden Surname) rie Campbe | 11 |
| Mary | s 1 and 2 should I f Health and Men item 27 is marke other traumatic | <u>۵</u> | 19a. Informant's Name/Relations Renata R. Bris | | ter | | | | | er, City or Town, State | |
| | t and the Health Item 27 | | 20a. Method of Disposition | | 20b. Pla | ace of Dispo | sition (Name of natory or other pla | ce) | Date | 20c. Location - City of | or Town, State |
| Baltimore, | | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | 9 (| | l Cemeter | 1 1 - | 9/2009 | Hagerstov | m, MD |
| att | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Service | Licensee | | 22 | 2. Name and Addre | ess of Facility Ge | | | uneral Home |
| n | 8 9 E 8 9 | 1.5 | 1/12/7 | | | | | | | gerstown, | |
| | | | 23a. Part 1. Enter the disease, or shock, or heart failure. List | complications that cause only one cause on each | ed the death. line. | Do not ent | er the mode of dyi | ng, such as cardiad | c or respiratory ar | rrest, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | | | | CARCU | NOMA | | | |
| | /Medical Examiner | | resulting in dealtry | Due to (or a | s a conseque | ence of): | | | | | |
| | | آو ا | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events | b Due to (or a | s a consequ | ence of): | | | | | |
| | ate be executed hysician and he burial-transit | Examiner | Cause (Disease or injury that initiated events | с | | | | | | | |
| 760, | oe execian a | | resulting in death) Last | Due to (or a | s a consequ | ence of): | | | | | |
| 687 | physicate I | dical | | d | | | - | | | | |
| O. Box 6 | Attending Physician: The law requires that the death certificat redath. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown | 2 ☐ Fetal at time of de | death 3[| ☐ Ectopic pregnan ☐ Other (specify) _ | су | | 23 d. Date of o | delivery Day Year |
| σ. | that the | Phy | Part II. Other significant conditi | ons contributing to death | but not resu | Iting in the u | nderlying cause gi | ven in Part I. | 23e. Did to | obacco use contribute | to the cause of death? |
| rds, | v requires that the de been signed by the should be detached | d by | | | | | | | 1 🗆 ` | Yes 2□No 3□ | Probably 4 Unknown |
| Records, | ne law rec e has bee ge 2 shou | Completed | | | | - | | | | osy prior t rmed? death | |
| | in: The ifficate or, pa | | 25. Was case referred to medica | | | | | 26. Place of Dea | 1 ∐Yes ath <i>(Check only c</i> | 2 MNo 1 □Y one) | es 2 No |
| <u>=</u> | ysicia is cer direct | o Be | examiner? 1 ☐ Yes 2 ☐ No | Hoonitoly | tient 2 🔲 I | ER/Outpatie | nt 3 □ DOA Ot | her: 4 Nursing H | Home 5 ☐ Resi | dence 6 Other | RONS ITOSPICE |
| o uo | ding Physician: The h. After this certificate h. funeral director, page | tion: 1 | 27. Manner of Death 1 | 28a. Date of Ir (Month, L | njury Day, Year) | 28b. Time o Injury | Wo | ıry at rk?]Yes 2 □No | 28d. Describe | how injury occurred | |
| Division of Vital | I or Attencater death Director: | Certification: To | 2 Accident Invest 3 Suicide 6 Could 4 Homicide detern | not be 28e Place of I | njury - At ho etc. <i>(Specif</i> y | me, farm, st | reet, factory, office | | 28f. Location (: City or Tox | Street and Number or wn, State) | Rural Route Number, |
| _ | Hospital 4 hours Funeral tely filled | Medical Co | 29a. Certifier 1 Certify (Check only one) 2 Medica | ng Physician: To the be i Examiner: On the basis and manner | of examinat | wledge, dea tion and/or i | th occurred at the nvestigation, in my | time, date and plac opinion, death occ | e, and due to the urred at the time, | cause(s) and manned date and place, and d | as stated. due to the cause(s) |
| | To the within 2 To the comple | Mec | 29b. Signature and title of certific | er | | | 29c. Licer | se number | | 29d. Date signed (Mo | |
| | F ≶ F ŏ | | > A Quality | 12 Burton | | | H49 | 931 | | March | 13447018 |

OH-10

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Avenue Apt 203 Balhmare MU

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 12:45 AM 9 09 Marie Μ. Brown /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisbury 31686 Kenilworth Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min 1 □ M 2 🖾 F 7-30-1922 West Virginia 86 Director 217-44-2117 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a4 show amy injury or other traumatic event, if whedical Exh. it is count to conflict an once. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ☐ Yes 2√☐ No Director Salibury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 31686 Kenilworth Drive 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Hospital** Food Service Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Graham Nannie ပ Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 418 Lindenhurst Court, Salisbury, Maryland 21804 Betty Adams - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-9-2009 Crematory of Delmarva Delmar, Delaware 22. Name and Address of Facility gnature o Funeral Service Licensee Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final 2 mis. Physician Or CLHO MA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. En the Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed as the burial-tran the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 □ Yes 2 🗷 No 1 ☐Yes 2 X No : After this certification in the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector, the sector is sector in the sector is sector. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at To the Hospital or Attending 1 Natural 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) On BIOI Salisbury Md. 21801 Riverside 560 31. Date filed (Month, Day, Year) MAR 10 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death A Physician Year harles 2009 Denson /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death * HICAMIO TENINSULA REGIONAL MEDICAL SALISBURY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F Months Days Min **Director** 213-24-0112 -30-1929 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f ethoriany injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Somerse 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2 No. 1 Yes, Give Year or Dates: 2-23-1951 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -14-2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 917 Isabella Smith F. H -Sulisbury 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** 51 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 **□**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home Certification: To 1 ☐ Yes Ž⊠No 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending n 24 hours after death. le Funeral Director: A bletely filled in by the ft 2 Accident investigation 1 🗆 Yes 2 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** P_M 2, 2009 835 Rebecca Ann Cooper March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2360 Barksdale Rd. Ceci1 E1kton If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9/5/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🛣 F 76 Delaware 222-18-8015 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show traumatic event, the Medical Evar-tinar must be nutified at New Castle 1 ☐ Yes 2X No DE Wilmington Director 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ō 19808 2015 Limestone Rd united States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22∐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2XNo Specify White Specify: ģ 3 Widowed 4 □ Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Retail Antique Dealer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other I amy Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifford Elsie May Dyer Reaume ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2360 Barksdale Rd Elkton, MD 21921 Cora L. Bechard/ Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gracelawn Memorial Park 3/6/2009 New Castle, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Spicer-Mullikin Funeral Homes Inc 1000 N. DuPont Hwy New Castle, DE 19720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) P.0. the 9 I Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ No. 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be I Other: 4 Nursing Home 5 Residence 1 Yes 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) this Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After t After 1 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Descritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) MAR 12

29b. Signature and

016

title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

| | 1 - For State of Mary Registrar | rland / Department of Health and I Certificate of Death | Mental Hygiene |
|--|---|---|--|
| Physician /Medical | 1. Decedent's Name (First, Middle, Last) Hazel Virginia Cramer | | 2. Date of Death Month Day Year Year 11. 47PM |
| Examiner Funeral | | 4b. City, Town, or Location of Death A Plate Dyrs. last birthday) If Under 1 Year If Under 24 Hrs. | a Charles 8 Date of Birth 9 Birthology (State or Family) |
| Director | 215-36-4491 1 M 2 XF 72 Usual Residence of Decedent | Yrs. Months Days Hours Min. | May 16 36 Country Washington, DC |
| Maryland f show | 36 1 1 00 1 | c. City, Town or Location La Plata | 10d. Inside City Limits 1 ☐ Yes 2 👿 No |
| vith the Mar or 28a-f s | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| fter death w r items 23a in r in und | 5675 Ripley Park Drive 11. Marital Status 12. Was Decedent Ever | in U.S. 13. Was Decedent of Hispanic Origin? (S | USA pecify Yes or No- 14. Race - American Indian. |
| 5-0030 72 hours after c natural", or iter fical Examinar | 3 ▼ Widowed 4 □ Divorced If Yes, Give Year or Dates: | in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: | o Rican, etc.) Black, White, etc. Specify: White |
| partition of e., Maryiand 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Date Processing | sking 16b. Kind of Business/Industry Southern Bank of Maryland |
| id be filed tental Hyg ked other ic event, o Be C | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Maiden Surname) |
| Maryta d 2 should } th and Men th and Men traumatic | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailing Address (Street and Number or Ru | therine Thompson ural Route Number, City or Town, State, Zip Code) |
| E, IVI | Mary K. Estep/Sister 20a. Method of Disposition 2 | 7625 Estep Place, Char | |
| mit. Pages partment of portant: If ite y Injury or o | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | daryland Veterans Cem. Ma | Date 20c. Location - City or Town, State 2009 Cheltenham, MD |
| Dermit. Departit Departit Imports any Inji | 21. Signature of Funeral Service Licensee MO | 22. Name and Address of Facility Bri 30195 Three Notch | nsfield-Echols F.H., P.A., Rd., Charlotte Hall, MD 20622 |
| ficate be executed ficate be executed physician and sthe burial-transit and sthe burial-transit addical Examiner | | nsequence of): | c or respiratory arrest, Approximate Interval Between Onset and Death |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death certificate be should be detached for use as the burnerial Director. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burnerial Director. To Be Completed by Physician/Medical | d | Fetal death 3 ☐ Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| v requires that been signed be detected by Please by Ple | S F D S I C | t resulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown |
| The law required to the cate has been spage 2 should | | | 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No |
| sician: s certific irector, | 25. Was case referred to medical examiner? | Other | th (Check only one) |
| nding Physath. Tr. After this e funeral dir | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Yea | 28b. Time of 28c. Injury at | ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred |
| tal or Attending F rs after death. al Director: After led in by the funers Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S | At home, farm, street, factory, office pecify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| o the Hospit ithin 24 hour o the Funer ompletely fill Medical (| 29a. Certifier (Check only one) 100 Certifying Physician: To the best of my one) 100 Certifying Physician: To the best of my one and manner stated. | y knowledge, death occurred at the time, date and place mination and/or investigation, in my opinion, death occu | e, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s) |
| To th Withir To th comp | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | 30. Name and advress of person who completed cause of death | (Item 23a) (Type, Print) | MAKCH 14 2009 |
| | Ashvin Patel MD, 102 Paul | 1 Mellon Court Suite | 102 (valdorf, MD 20602 |
| State Registrar | 31. Date filed (Month, Day, Year) MAK 2 U 2009 32. Régistrar's S | | |

| | | | 1 - For State of Ma | | | rtment of H | | and Me | | iene g. No. 2 | 009 | 09418 |
|----------------|--|-------------------|--|--|----------------------------|---|---------------------------------------|--------------------------|--|--------------------------|---|---|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Robert Lee Chronister, | Jr. | | | | - | 2. Date of Death Month March | | 009 | 3. Time of Death 0014 M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) 1915 Old Taneytown Road | | | 4b. City, Town, or Westmi | inste | r | | C | nty of Death | |
| a. | Funeral Director | | | e (In yrs. last birt | thday) Yrs. | If Under 1 Year Months Days | If Under 2 Hours | Min. | B. Date of Birth (Month, Day, Sep 12, | ^{Year)} 1972 | 9. Birthi Cour Mary | place (State or Foreign ntry) Yland |
| | Maryland -f show lied at | tor | 10a. State 10b. County Maryland Carroll | 10c. City, Town | n or Lo | | tmins | ter | | | 1 | 10d. Inside City Limits 1 □Yes 2 No |
| | h with the | Funeral Director | 10e. Street and Number 1915 Old Taneytown Road | | | 10f. Zip Code | 211 | 58 | 11 | | of What Coul | ntry? |
| 030 | 'natural', or items 23a or 28a-f show calcut Exeminating to another adjust to a | by | 11. Marital Status 1 Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates: | | | Was Decedent of Hi f Yes, specify Cuba I □Yes 2 🕱 No | spanic Oric n, Mexican Specify: | gin? (Spec , Puerto R | ify Yes or No- ican, etc.) | | Race - Americ lack, White, cify: wh | |
| 21215-0036 | be filed within 72 ho ital Hygiene. d other than "natur event, Ine Medicali. | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5- | | (Give life. I | dent's Usual Occupa kind of work done d DO NOT use retired, Disabled | ation Juring most) | of working | 7 | | Business/In | dustry |
| yland | 2 should be filed and Mental Hyu is marked othe raumatic event, | To Be C | 17. Father's Name (First, Middle, Last) Robert L. Chronister, Sr | | | | 18. Mother | | First, Middle, M gy Creb: | | ame) | |
| Mar | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once. | | 19a. Informant's Name/Relationship (Type. Print) Peggy Chronister, mother | 19 | 915 | g Address (Street a | ytown | Road | d, West | ninste | er, MD | 21158 |
| baitimore, | Pages † tment of H tant: If iter | | 20a. Method of Disposition 1 | | UM | sition (Name of natory or other place Cemetery | 3 | Da /14/2 | 2009 | Hanove | n-City or To | |
| Dall | permit Depart Import any in | | 21. Signature of Funeral Service Licensee | | 13 | Name and Addres | imore | St, | Taneyto | wn, M | | |
| | Physician /Medical Examiner the bunal-transit | Examiner | Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a consequence of | 00 of): 1 Vi of). | XIA | | | ENSE | | | Approximate Interval Between Onset and Death |
| P.O. BOX 58/6U | death certific e attending p id for use as t | Physician/Medical | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal death | |] Ectopic pregnancy] Other (specify) | , | | | | Date of deliv Month | ery Day Year |
| cords, r | requires that the veen signed by th hould be detache | þ | Part II. Other significant conditions contributing to death but | it not resulting in | n the u | nderlying cause give | en in Part I. | | | acco use co | | he cause of death? bably 4 ☐ Unknown |
| Hec | The la ate has | Completed | | | | | | | 24a. Was ar autops perform 1 □ Yes 2 | y | b. Were auto prior to co death? 1 ∐Yes | opsy findings available impletion of cause of |
| VII | Physiclan: r this certific ral director, I | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatie | | | Othe | 3r. | | (Check only on | | | |
| DIVISION OF | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: To | 27. Manner of Death 1 | y, Year) | Time o | 28c. Injury Work | 4 LI NU | No 28 | e 5 Reside 3d. Describe ho 3f. Location (St. | w injury occ | urred | fy) al Route Number, |
| 2 | spital or ours after ours after ours after ours filled in b | | 4 Homicide determined building, etc. 29a. Certifier Certifying Physician: To the best of | | | | ne. date an | d place, a | City or Town | | manner as | stated. |
| | o the Hos ithin 24 h o the Fur ompletely | Medical | (Check only one) 2 Medical Examiner: On the basis of and manner start and title Scertifier | f examination an | nd/or in | vestigation, in my o | pinion, dea | th occurre | d at the time, d | ate and plac | e, and due t | o the cause(s) |
|) | MIL | | I Want C. XINOA | | MI |) DOO | 5555 | | | 3/11/ | 109 | |
| | 9 | | 30. Name and address of person who completed cause of de | eath (Item 23a) : CHNNB ar's Signature | (lype, | POOA-POO | Ve 1 | 4) (| NESTM. | NSTE | RM | 104/157 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) MAR 1 2 2009 MAR 1 2 2009 | us Signature | | bares | | | | | | |

Registrar DHMH 17 Rev 1/2001

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

menny

, mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

werner

29c. License number

1152830

900 Bestacti Road#300, Amepolis, mo

29d. Date signed (Month, Dey, Year)

March 11,200

State of Maryland / Department of Health and Mental Hygiene For State Registrar 09420 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** \mathbf{P} M PAUL LEROY COLE, JR 6:45 MARCH 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2107 MAIN STREET CHESTER QUEEN ANNE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **X** M 2□ F Months Days Hours 221-20-8562 MAY 18, 1935 Director DELAWARE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 □Yes 2X No ns 23a or 28a-f sl must be rotified MARYLAND QUEEN ANNE'S CHESTER Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2107 MAIN STREET 21619 UNITED STATES death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give KOREAN Year or Dates: WAR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or item or other traumatic event, Ite Medical Examinat Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify Specify: ģ 3 Widowed 4 NDivorced Completed 16a. Decedent's Usual Occupation 16b: Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRUCKING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL LEROY COLE, SR ELLEN UNKNOWN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LULA MAE COLE/EX-WIFE 2107 MAIN STREET, CHESTER, MARYLAND 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o MARCH 13 1 Burial 2 □ Cremation 3 Removal from State STEVENSVILLE, MARYLAND STEVENSVILLE CEMETERY: 4 ☐ Donation 5 ☐ Other (Specify) 2009 of Fuper 22. Name and Address of Facilit FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been si 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 □ No 2 **A**No 1 □ Yes □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes So No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 🖐 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 9030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 v 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State 1 1 2009 MAR Registrar

DHMH 17 Rev 1/2001

Registrar

NAR 11 2009

09-01911 Carolyn Cooney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 09422

| | | 1- For State Certificate of Death Reg. No. | 0 2 4 5 | | | | | | |
|--|---|--|--|--|--|--|--|--|--|
| Physici | | 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Ti | ime of Death | | | | | | |
| edical Exami | ner | Calolyn A. Cooney | 956 hrs | | | | | | |
| | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | | | | | | | |
| | | 7405 Vinyard Court Derwood Montgomery | | | | | | | |
| Funeral | | 5: Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplac | ce (State or | | | | | | |
| Director | | 213-06-0460 1 M 2 X 39 Yrs. Months Days Hours Min. June 21, 1969 Country |) MD | | | | | | |
| | | Usual Residence of Decedent | | | | | | | |
| v any | | | Inside City Limits | | | | | | |
| and shov | 5 | Maryland Montgomery Derwood | Yes 2 XNo | | | | | | |
| Maryl. 28a-f d at o | Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? | | | | | | | |
| the land | | | | | | | | | |
| r with ms 2. | uneral | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American II 15. Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American II 15. Never Married 2 Married Armed Forces? | ndian, Black, | | | | | | |
| death or ite | Ë | | | | | | | | |
| after | by I | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Whit | | | | | | | |
| hours natu | pe | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indust The Associate | ed Gen. | | | | | | |
| 36 in 72 han " | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) Director Contractors | | | | | | | |
| with giene | om | 2 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) | | | | | | | |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica | a) | φ Richard E. Cooney Mary 1. Fitzsimmons | - | | | | | | |
| 212 uld be Ment mark | .0 B | O 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip | Code) | | | | | | |
| MD id 2 sho lith and m 27 is | 7 | Richard E. Cooney (Father) 7405 Vinyard Court, Derwood, Maryland 208 | 855 | | | | | | |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town | n, State | | | | | | |
| Baltimore, permit Pages I ar Department of Hee important: If ite njury or other tr | | 1 XBurial 2 Cremation 3 Removal from State All Souls Cemetery Appendion 5 Other Specify Germantown, I | MD | | | | | | |
| Itin lit Partme artme ortan | | 4 Donation 5 Other Scienty: 2009 21. Signature of Funeral Septice Licensee 22. Name and Address of Facility DeVol Funeral Home, | | | | | | | |
| Dep Dep Inju | k y | TRAM A Stude 10 E. Deer Park Drive, Gaithersburg, M | D 20877 | | | | | | |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Ap | proximate Interval | | | | | | |
| /Medical | g es | failure. List only one cause on each line. Immediate Cause (Final disease a, Meningitis | etween Onset and Death | | | | | | |
| xaminer | | or condition resulting in death) Due to (or as a consequence of): | | | | | | | |
| | | Sequentially list conditions, b. | | | | | | | |
| | Examiner | if any, leading to immediate Due to (or as a consequence of): | | | | | | | |
| ے ک | хаш | (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | |
| executed an and al - transit | | | | | | | | | |
| 760, icate be executed physician and the burial - transi | /Medical | UNPENDED | | | | | | | |
| 760, ficate be g physici s the buri | Me /Me | F FEMALE: 23d. Date of delivery 23d. Date of delivery Apply Ap | | | | | | | |
| 68 certif nding | | Eetal death 3 Ectopic pregnancy Month Day | Year | | | | | | |
| tal Records, P.O. Box 68760, cian: The law requires that the death certificate be certificate has been signed by the attending physici ector, page 2 should be detached for use as the buri | Physicia | 1 Yes 2 No 9 V Unknown g Unknown | 1 | | | | | | |
| O. For the lached | | | cause of death? | | | | | | |
| P.O. res that th signed by be detach | d by | 1 Yes 2 No 3 Probably | 4 V Unknown | | | | | | |
| rds requi | Completed | 24a. Was an 24b. Were autopsy autopsy prior to compl | y findings available letion of cause of | | | | | | |
| e law e has | ם | gerformed? death? | | | | | | | |
| | | | 2 No | | | | | | |
| 'ita siciar is cer irecto | B | examiner? | ene | | | | | | |
| n of Vital Rec ding Physician: The L After this certificate b funeral director, page | : To | 77 Means of Death | | | | | | | |
| Division of Vital Records, sale Attending Physician: The law requirements and recent the sale been similar by the funeral director, page 2 should be in by the funeral director, page 2 should be | ig | 1 V Natural 5 Pending (Month, Day, Year) | | | | | | | |
| risic r Atte er de: recto | fica | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural R | Route Number, City | | | | | | |
| ital or | Certification: | Suicide 6 Could not be determined (Specify) | | | | | | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | al C | | | | | | | | |
| o the ithin of the on the | 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Cheek only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | | |
| 10 | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | | | | | | | | |
| 10 | 9 h) | (a) o.C.M.E. March 8, 2009 | 1 | | | | | | |
| | | 30. Name and address of person who completed cause of death (Item 23a) | | | | | | | |
| _ | | Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | | | | | | | |
| | tate | | | | | | | | |
| Regis | urali | ar MAN I I 2003 Service S. March | | | | | | | |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| an | Decedent's Name (First, Middle, I | INF,3/16/0 | M'nes'lor | D Ce | rtificate of | Dealli | 2. Date of Dea | Reg. No. C | 09 | 0 9 4 | |
|--|--|--|---|--|--|---|--|---|---|---|--|
| | T. Doodding Haine (First, Middle, I | | 31 | | | | Month | Day | Year | 8:50 | |
| cal | 4a. Facility Name (If not institution, | Pung Eun C | | | 4h City Town o | r Location of Dea | March | 4c Count | 2009 y of Death | | |
| ner | | | | | | | | | nce Ge | orean La | |
| | 7604 Lake Glen Dr 5. Social Security Number 6 | . Sex | 7. Age (In yrs. I | last birthday) | If Under 1 Year | | | h | 9. Births | place (State or F | |
| | 214-08-4283 | 1 X M 2 □ F | 68 | Yrs. | Months Days | Hours Min | . (Month, Da February | | Cour | ntry) Japan | |
| | Usual Residence of Decedent | | | | | | | | | | |
| <u>_</u> | 10a. State 10b. County | | 10c. City | y, Town or Lo | ocation | | | | 1 | 10d. Inside City L | |
| Director | Maryland Prin | Glenn | Dale | | | | 1 □ Yes 2 | | | | |
| Ö | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of South 1 | izen of What Country? | | |
| Funeral | 7604 Lake Glen Drive 11 Marital Status 12. Was Decedent Ever in U.S. 13. V | | | | Was Decedent of I | 20769 | Cracify Van ar Na | | -U.S.A | non Indian | |
| i. | 11. Marital Status 1 □ Never Married 2 ☑ Married | Armed Fo | orces? | 5. 13. | Was Decedent of I If Yes, specify Cub | an, Mexican, Pue | rto Rican, etc.) | | ce - Americ ick, White, | | |
| b | 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No | Specify: | | Specia | fy: | | | | | |
| bel | 15. Decedent's | dent's Usual Occup | oation | 16b. Kind of E | Business/Inc | Asian dustry | | | | | |
| Completed | (Specify only highest of Elementary/Secondary (0-12) | grade completed) College (1 | 1-40r 5 ı \ | (Give life. | kind of work done DO NOT use retire | during most of wo d) | orking | | | | |
| ο. | 12 | | 1 407 017 | | 0wne | r | | Dry | Clean | ers | |
| To Be Completed by Funeral Director | 17. Father's Name (First, Middle, La | st) | | | | 18. Mother's Na | me (First, Middle, | Maiden Surnai | me) | | |
| 10 | Gae Sik Chang | | | | | | e Kwack | | | | |
| | 19a. Informant's Name/Relationship | ng Address (Street | and Number or F | Rural Route Numbe | er, City or Town | , State, Zip | Code) | | | | |
| | Yong Kyo Chang - Wi | .fe | | 7604 | Lake Glen | Drive, G1 | enn Dale, N | Maryland | 20769 | | |
| | 20a. Method of Disposition | □ Domount from | | lace of Dispo | osition (Name of matory or other pla | ce) | Date | 20c. Location | - City or To | own, State | |
| | 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | I | rt Linco | oln Cremato | ry 03 | /13/2009 | Brentwo | od, Ma | ryland | |
| | 21. Signature of Funeral Service Lic | censee / | | | 2. Name and Addre | | II T | | | | |
| | Myslin . K | beck | | | lines-Rinal .1800 New H | | | | g. Mar | vland 209 | |
| | shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Interval Betwee Onset and Death Death | | | | | | | | | | |
| Examiner | d | | | | | | | | | | |
| ca | | d | (or as a consequ | uence of): | | | | | | | |
| ca | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 1 ☐ Live | tcome of pregna birth 2 □ Fetal | ncy | □ Ectopic pregnand □ Other (specify) _ | sy | | | ate of delive | ery Day Yea | |
| by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1 □ Live 4 □ Preg 9 □ Unkr | tcome of pregna birth 2□ Fetal nant at time of d nown | incy I death 3 [leath 5 [| Other (specify) _ | | | obacco use con | onth tribute to th | | |
| Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical | 1 □ Live 4 □ Preg 9 □ Unkr | tcome of pregna birth 2□ Fetal nant at time of d nown | incy I death 3 [leath 5 [| Other (specify) _ | ven in Part I. | 1 🗆 Y | obacco use con yes 2 \(\omega \) No an sy rmed? 2 \(\omega \) No | onth 3 Prot Were auto prior to co death? | Day Yea | |
| Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions | 1 Live 4 Preg 9 Unkr | tcome of pregna birth 2□ Fetal nant at time of d nown | ncy I death 3 [leath 5 [ulting in the u | Other (specify) _ | zen in Part I. 26. Place of De | 24a. Was autop perfor 1 □ Yes | Mobacco use cor 'es 2 ⊠ No an 24b. sy ymed? 2 ⊠ No | onth 3 Prot Were auto prior to co- death? 1 Yes | he cause of deal pably 4 □ Unk popsy findings availing august 2 □ No | |
| To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death | 1 Live 4 Preg 9 Unkr s contributing to de | tcome of pregna birth 2 Petal nant at time of d nown eath but not resu Inpatient 2 of Injury | eath 3 [eath 5 [ulting in the u ER/Outpatie: | ☐ Other (specify) _ nderlying cause given nt 3☐ DOA Other | zen in Part I. 26. Place of Dener: 4 □ Nursing | 24a. Was autop perfor | Mobacco use cor yes 2 ⊠ No an 24b. sy ymed? 2 ⊠ No | onth all Prot Were auto prior to co death? all Yes her (Specif | he cause of deal pably 4 □ Unk popsy findings availing august 2 □ No | |
| To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending investigat | 1 Live 4 Preg 9 Unkr s contributing to do Hospital: 1 28a. Date (Monitor) | tcome of pregna birth 2 Petal nant at time of d nown eath but not resu | ncy I death 3 [leath 5 [ulting in the u | Other (specify) _ nderlying cause given nt 3 □ DOA Other 28c. Inju Wor | zen in Part I. 26. Place of Dener: 4 □ Nursing | 1 □ Y 24a. Was autop perfor 1 □ Yes eath (Check only only only only only only only only | Mobacco use cor yes 2 ⊠ No an 24b. sy ymed? 2 ⊠ No | onth all Prot Were auto prior to co death? all Yes her (Specif | he cause of deal pably 4 □ Unk popsy findings availing august 2 □ No | |
| To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending Investigat 3 □ Suicide 6 □ Could not | Hospital: 1 28a. Date (Mon) be defected 28e. Place | Inpatient 2 of Injury - At ho | eath 3 [leath 5 [leath 5 [leath 5 [leath 5 [leath 5 [leath]]]]] | Other (specify) _ nderlying cause given nt 3 □ DOA Other 28c. Inju Wor | 26. Place of Dener: 4 ☐ Nursing ry at | 1 □ Y 24a. Was autop perform 1 □ Yes eath (Check only of the chart) 28d. Describe h 28f. Location (\$200) | M obacco use cor yes 2 ☒ No an sy ymed? 2 ☒ No lence 6 ☐ Ot low injury occur Street and Num | onth 3 Prot Were auto prior to co death? 1 Yes | he cause of deal pably 4 □ Unk popsy findings availing august 2 □ No | |
| To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending investigat 2 □ Accident investigat 3 □ Suicide 6 □ Could not | Hospital: 1 28a. Date (Mon) be defected 28e. Place | Icome of pregna birth 2 Petal nant at time of d nown eath but not resu Inpatient 2 of Injury tth, Day, Year) | eath 3 [leath 5 [leath 5 [leath 5 [leath 5 [leath 5 [leath]]]]] | Other (specify) _ nderlying cause given nt 3 □ DOA Other f 28c. Inju Wor in the content of t | 26. Place of Dener: 4 ☐ Nursing ry at | 24a. Was autop perfor 1 Yes eath (Check only o | M obacco use cor yes 2 ☒ No an sy ymed? 2 ☒ No lence 6 ☐ Ot low injury occur Street and Num | onth 3 Prot Were auto prior to co death? 1 Yes | Day Year he cause of deat bably 4 □ Unk upsy findings avampletion of caus 2 □ No | |
| Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Monibe add 28e. Place buildi Physician: To the aminer: On the b | Inpatient 2 of Injury - At hoing, etc. (Specify | ER/Outpatier 28b. Time o | Other (specify) _ nderlying cause given nt 3 □ DOA Other f 28c. Inju Wor in the content of t | 26. Place of Depart I. 26. Place of Depart 4 Nursing ry at k? Yes 2 \bigcap No | 24a. Was autop performed to the control of the cont | Mobacco use cor Yes 2 No An 24b. Symmed? 2 No An 24b. | onth 3 Prot Were auto prior to co death? 1 Ves her (Specificate) | Day Year he cause of deat bably 4 \(\buildrel{\text{Unk}} \) Unk posy findings availing the cause 2 \(\buildrel{\text{No}} \) No | |
| To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Monibe add 28e. Place buildi Physician: To the aminer: On the b | Inpatient 2 of Injury th, Day, Year) e best of my knowasis of examina | ER/Outpatier 28b. Time o | Other (specify) _ nderlying cause give nt 3 □ DOA Other f 28c. Inju Wor M 1 □ reet, factory, office h occurred at the t | 26. Place of Dener: 4 ☐ Nursing ry at K? Yes 2 ☐ No | 24a. Was autop performed at the time, | Mobacco use cor Yes 2 No An 24b. Symmed? 2 No An 24b. | onth Solution Solution | he cause of deal bably 4 \(\subseteq \text{Unk} \) posylindings avainpletion of cause 2 \(\subseteq \text{No} \) all Route Number stated, of the cause(s) | |
| edical Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 1 28a. Date (Monibe add 28e. Place buildi Physician: To the aminer: On the b | Inpatient 2 of Injury th, Day, Year) e best of my knowasis of examina | ER/Outpatier 28b. Time o | Other (specify) _ nderlying cause given nt 3 □ DOA Other f 28c. Inju Mon 1 □ reet, factory, office h occurred at the top of the specific property of the specific prop | 26. Place of Depart I. 26. Place of Depart 4 Nursing ry at k? Yes 2 No | 24a. Was autop performed at the time, | M obacco use cor res 2 ☑ No an sy rmed? 22 ☑ No dence 6 ☐ Ot row injury occur Street and Num m. State) cause(s) and n date and place | onth Solution Solution | he cause of deal bably 4 \(\subseteq \text{Unk} \) posylindings avainpletion of cause 2 \(\subseteq \text{No} \) all Route Number stated, of the cause(s) | |
| edical Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Hospital: 28a. Date (Monibe add 28e. Place buildi Physician: To the aminer: On the band man | Inpatient 2 of Injury th, Day, Year) e best of my knowasis of examina | ER/Outpatier 28b. Time of Injury me, farm, striv) wledge, deattion and/or in | Other (specify) _ nderlying cause give nt 3 □ DOA Other f 28c. Inju Wor M 1 □ reet, factory, office th occurred at the top to the street of the street | 26. Place of Dener: 4 ☐ Nursing ry at K? Yes 2 ☐ No | 24a. Was autop performed at the time, | M obacco use cor res 2 ☑ No an sy rmed? 22 ☑ No dence 6 ☐ Ot row injury occur Street and Num m. State) cause(s) and n date and place | onth Solution Solution | he cause of deal bably 4 \(\subseteq \text{Unk} \) posylindings avainpletion of cause 2 \(\subseteq \text{No} \) all Route Number stated, of the cause(s) | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | 1 | For State Registrar | State of Maryle | | Certificate of I | | Reg. N | 2009 | 09424 |
|----------------------------|--|---------------------------|--|---|----------------------------|---|---|--|-----------------------------------|---|
| | Physicia | | 1. Decedent's Name (First, Mic | | 01. | | | Date of Death Month D |)ay Year | 3. Time of Death |
| | Physicia /Medic | al - | | ne Ashford Tobey | Choir | | r Location of Death | HRCH _ | c. County of Deat | |
| | Examin | er | 4a. Facility Name (If not institu | DICAL CENTER | | I E PLE | TA | 1 - | THARLES | 5 |
| | Funeral | | 5. Social Security Number | 6. Sex 7. Age (In y | | Months Davs | If Under 24 Hrs. 8. Hours Min. | Date of Birth (Month, Day, Yea arch 10, | | thplace (State or Foreign ountry) |
| | Director | - | 447-32-4827 Usual Residence of Decedent | 1□M 2XF 73 | 3 ' | rs. | Ma | arch 10, | 1935 01 | <u>K</u> |
| \circ | yland now | | 10a. State 10b. Cour | nty 10c. | City, Town | or Location | | | | 10d. Inside City Limits |
| 3 | e Mar | ctor | MD (| Charles | La | Plata | | 10- (| Citizen of What Co | 1 🕅 Yes 2 □ No |
| M4357CC | death with the Maryland ems 23a or 28a-f show r must be notified at | Funeral Director | 10e. Street and Number 101 Weslev Di | rive, Unit 105 | | 10f. Zip Code 2064 | 46 | | USA | oriti y : |
| 0 | ms 23 | nera | 11. Marital Status | 12. Was Decedent Ever in | n U.S. | | lispanic Origin? (Specify an, Mexican, Puerto Rica | | 14. Race - Ame Black, White | |
| 21215-0036 | ermit. I ages 1 and 2 should be filed within 72 hours after death with the Marylan epartir ent of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Expansion must be notified at my injury or other traumatic event, the Medical Expansion. | | 1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 🛂 Divord | | | 1 □Yes 2 🛣No | | | Specify: | White |
| 2.5 | 72 ho "natur | Completed by | 15. Dece (Specify only hig | dent's Education ghest grade completed) | 16a. | Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | oation during most of working d) | 16b. | Kind of Business/ | Industry |
| 121 | within iene. than | dwo | Elementary/Secondary (0-12 | 2) College (1-4or 5+) | | Clerk | <i>.</i> , | C | onvenien | ce Store |
| Shir | d be filed ental Hyg ked other ic event, | To Be C | 17. Father's Name (First, Midd Leonard Ashf | | | | 18. Mother's Name (Fi | | en Surname) | |
| Mary | and M s mar | - | 19a. Informant's Name/Relation | onship (Type. Print) | 19b. | Mailing Address (Street | and Number or Rural R | oute Number, Cit | y or Town, State, | Zip Code) |
| .) | and 2 lealth m 27 I | | Bonita Callov | | | 2500 Shiloh | | | g, MD 200 Location - City or | |
| Chomple, Baltimore, | rent of Hart of Hart: If ite | | 4 ☐ Donation 5 ☐ Other | on 3 \square Hemoval from State r (Specify) | cemeter Crinit | Disposition (Name of y, crematory or other place y Memorial | Gar 3/13/2 | 2009 Wa | ldorf,Man | |
| Balt | ermit epart mport ny inj | | 21. Signature of Funcial Serv | dice Lifensee M01458 | | | CHOLS' FUNEI | | | 1.6 |
| | | | 23a. Part 1. Enter the disease | e, or complications that caused the c List only one cause on each line. | death. Do r | not enter the mode of dyi | fary's Ave. ng, such as cardiac or re | La Plat: espiratory arrest, | a, MD 2064 | Approximate Interval Between |
| | Physician | | shock, or heart failure. Immediate Cause (Final disease or condition | List only one cause on each line. | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a con | | | | | ii. | |
| | Lxammer | ē | Sequentially list conditions, if any leading to immediate | b | nsequence o | of): | | | | _ |
| 5 | cuted id ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 1 . | | | | Q. | | |
| ,00 | icate be executed physician and the burial-transit | Exa | | | | | | | | |
| 68760, | tificate be executed ig physician and as the burial-transit | Medical | | d | | | | | | |
| O. Box 6 | attendir for use | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome of pr 1 | Fetal death | 3 ☐ Ectopic pregnan 5 ☐ Other (specify) | су | | 23d. Date of de Month | elivery Day Year |
| σ. | w requires that the de been signed by the should be detached | | | ditions contributing to death but not | t resulting in | the underlying cause gi | ven in Part I. | 23e. Did tobacc | o use contribute t | to the cause of death? |
| rds | quires en sigr uld be | ed by | | | | | | 1 🗆 Yes | 2 Z No 3 □ F | Probably 4 🗌 Unknown |
| Division of Vital Records, | The law re ate has bei | Completed | | | | | | 24a. Was an autopsy performed 1 □ Yes 2 □ | l? death? | autopsy findings available completion of cause of s 2 □No |
| /ital | ician: The certificate rector, pag | BeC | 25. Was case referred to mee | | | | 26. Place of Death (C | | | |
| of V | Physic this or | | 1 Yes 2 No 27. Manner of Death | | | mpatient 3 100A | her: 4 Nursing Home | 5 Residence | | ecify) |
| uo | iding P th. : After | tion | 1 ☑ Natural 5 ☐ Pe | 28a. Date of Injury ending (Month, Day, Yea vestigation | ar) | njury Wo | ork? ⊒Yes 2 ⊒No | | ,, | |
| Divisi | al or Attendii after death. I Director: A d in by the fu | ertifica | 3 ☐ Suicide 6 ☐ Co | build not be termined 28e. Place of injury - building, etc. (S | At home, fa | rm, street, factory, office | 281 | Location (Stree City or Town, S | t and Number or F tate) | Rural Route Number, |
| ķ | To the Hospital or / within 24 hours after To the Funeral Direct completely filled in b | Medical Certification: To | 29a. Certifier 1 ☐ Cert (Check only 2 ☐ Med | tifying Physician: To the best of my lical Examiner: On the basis of exa and manner stated. | y knowledg amination ar | e, death occurred at the nd/or investigation, in my | time, date and place, an opinion, death occurred | d due to the caus at the time, date | e(s) and manner and place, and du | as stated. ue to the cause(s) |
| | To the within 2 To the comple | Me | 29b. Signature and title of ce | rtifier R.D | | 29c. Licer | nse number | 29d. | Date signed (Mor | nth, Day, Year) |
| | | | 10 10 | | | D-0 | 0056949 | | 0 4 0 | |
| | PRII | | 30. Name and address of pe | rson who completed cause of death | (Item 23a) | (Type, Print) Kama | akshi Baig, | M.D. | DLU | 6 |
| | SI | ate | 31. Date filed (Month, Day, | | Signature | 10 ds LA | I HI IT, IV | | UPT | ¥ |
| | Regist | | MAR | | 1 1. | parke | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CATRLDO GREGORY MARCH 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner REGIONAL SALISBIRG HICOMICS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Days 1 □ M 2 🔀 F 227-46-8990 Director JUNG 02 VIRCINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director CHINCOTERGUE ACCOMACIC VIRGINIA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 2 3 3 3 3 6 USA 4654 23a MAIN STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exerci 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: <u>م</u> 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ART ARTIST YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDITH PURVIS GREGORY KENNETH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4654 MAIN STREET CHINCOTENGUE VIRGINIA 23356 FRANK CATALDO SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State CREMATORIUM : 12 MARCH 2007 CHINCOTERGUE VIRGINIA 4 Donation 5 DOther (Specify) 22. Name and Address of Facility FEX & HOLSTON FUNCKAS. HOME 21. Signature of Funeral Service Licensee CHINCOTEAGUE, VIRGINIA 5049 CHICKEN CITY ROAD M. Dul you Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** oranary resulting in death) /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of): ate has been signed by the attending physician a page 2 should be detached for use as the burial-Box 68760, Physician/Medical IF FEMALE ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Vear 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HTN certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this 24 hours after death.

Funeral Director: After thi etely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DO053394

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

ANTHONY

31. Date filed (Month, Day, Year)

mo

ame and address of person who completed cause of death (Item 23a) (Type, Print)

mD

St. JAlisbury Md 2180/

| - | |
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| | |
| 68760, | |
| O. Box | |
| 1s, P.(| |
| Record | |
| f Vital | |
| Division of | |
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| | | Please Type or Print in Black II | ndelible ink. Ensure Al partment of Health and M | | • | | | |
|---|------------------|---|---|--|---|--|--|--|
| | 1 | - State Registrar Co | ertificate of Death | Reg | . No. 2009 | 09426 | | |
| Physician /Modical | | 1. Decedent's Name (First, Middle, Last) Sally Ann Cline | | 2. Date of Death Month | Day Year 17 2009 | 3. Time of Death | | |
| /Medical Examiner | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death BALTIMORE C | iTV | 4c. County of Death | | | |
| Funeral Director | | S_{INAI} HOS PITAL OF BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda $218-66-1452$ 1 M $218-66-1452$ 75 Yrs. | - 17 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 | 8. Date of Birth (Month, Day, Y April 18 | | place (State or Foreign | | |
| D | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or | ocation | APIII 10 | | yland 10d. Inside City Limits | | |
| Maryla a-f sho | - 1 | | ltimore | | | 1 X Yes 2 □ No | | |
| with the Mary | | 10e. Street and Number 1803 Thornbury Rd. | 10f. Zip Code 21209 | 10g | . Citizen of What Cou | ntry? | | |
| fter death w | 5 | | 3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- | U.S.A es or No- 14. Race - American Indian, | | | |
| Is a | 2 | Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: | 1 □Yes 2 No Specify: | Thoan, etc., | Black, White, | White | | |
| ed within 72 hou ygiene. her than "natura t, the Medical E | חבובו | (Specify only highest grade completed) (Gi | cedent's Usual Occupation we kind of work done during most of work or DO NOT use retired) | ing 16 | b. Kind of Business/Ir | dustry | | |
| ed with ygiene. | 5 | Elementary/Secondary (0-12) College (1-4or 5+) | N/A | (Clark Official) - Of | N/A | | | |
| weld be file Mental H arked oth atic even | 5 | 17. Father's Name (First, Middle, Last) Hubert Cline | | e (First, Middle, Ma Elizabet | | | | |
| 2 shoul and M is mar aumati | - | 19a. Informant's Name/Relationship (Type. Print) 19b. Ma | iling Address (Street and Number or Run | al Route Number, C | City or Town, State, Zi | o Code) | | |
| 1 and 2 Health em 27 wther tr | | Dacob Cline (Browner) | 66 Ritchie Rd. Smith | | . 21783 c. Location - City or To | own, State | | |
| Pages nent of int: If it | | 1 K I BUrial 2 I I Cremation 3 L Removal from State 1 | | カンス・コー | Smithsburg | | | |
| permit. Departn Importa any Inju once. | 1 | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility J.L. Davis Funeral | 1252 Home Smit | 25 Bradbury thsburg.Md | Ave. | | |
| 0 | | 23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between Onset and Death | | |
| Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | 5 | | - | few days | | |
| examiner un and italiansit | | | few days | | | | | |
| ate be executed hysician and he burial-transit | 9 | that initiated events resulting in death) Last C. Due to (or as a consequence of): d | | | | | | |
| ician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit | Iysiciai i/iviec | | 3 ☐ Ectopic pregnancy 5 ☐ Other (<i>specify</i>) | | 23d. Date of deliver Month | rery Day Year | | |
| es that igned b | L Ś | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | cco use contribute to | | | |
| v requir been s | | Coronary Array distage, hypo | on Ouro. | 1 ∐ Yes | 2 No 3 Pro | bably 4 Unknown | | |
| r: The lavicate has | nataldilloo | Syratione, respecting | James | autopsy performe 1 □Yes 2 | prior to co death? 1 ☐ Yes | a Mo | | |
| hysician this certif al director | | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpat | l Other | h (Check only one) ome 5 🗆 Residen | ce 6 ☐ Other (Spec | ify) | | |
| nding Ph th. : After th e funeral | 11011. | 27. Manner of Death ↓ Natural 5 □ Pending 2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time Injure (Month, Day, Year) 28b. Tim | of 28c. Injury at | 28d. Describe how | | | | |
| tal or Attending F rs after death. al Director: After led in by the funer? | 2 | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) | street, factory, office | 28f. Location (Stre City or Town, | et and Number or Rui State) | al Route Number, | | |
| | Medical | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated. | | | | | | |
| To th To th comp | M | 29b. Signature and title of certifier | 29c. License number | 290 | 1. Date signed (Month) | | | |
| | - | 30. Name and address of person who completed cause of death (Item 23a) (Type | KES OOO | | 3/11/0 | 9 | | |
| | | BAVI KANT MD, SINAI H | OSPITAL OF BAL | -TIMOR | E | | | |
| State Registra | | 31. Date filed (Month, Day, MAR 2 5 2009) ARR 2 5 2009 | 1. parl | | | | | |

DHMH 17 Rev 1/2001

DIL

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 012009 Jean Defibaugh March 12:44 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Kline Hospice House Mt. Airy | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) | February 27, 1 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖵 F 186-26-4813 73 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Frederick Maryland Frederick 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5955 Quinn Orchard Road, Apt. #137 21704 Funeral United States of America 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give X Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Caucasian þ 3 X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Book Keeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Cryder Jenny Blyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana R. Defibaugh (Son) 830 The Old Station Ct., Woodbine, MD. 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/19/09 Arlington National Arlington, Virginia 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licensee 3901 N. FAIRFAX DR., ARLINGTON, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3400 r Metas taho /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate backs. Enter the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature a title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson Dr. Frederick, MD r. Hiren Shah L50 Thomas,

DHMH 17 Rev 1/2001

State

Registrar

(Month, Day, Year)

MAR 10 2009

State of Maryland / Department of Health and Mental Hygiene 2 0 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 9, 2009 **Physician** 3:25a M Billie E. Dees /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Days 1 □ M 2 🗓 X NC August 22, 1932 Director 246-56-3067 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evertment in the notified at 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2XXXNo Silver Spring MD Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20901 10110 Kinross Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1∐Yes 2**XXX**No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Finance Elementary/Secondary (0-12) College (1-4or 5+) Head Teller 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fletis Watkins William J. Brown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10110 Kinross Avenue, Silver Spring, MD 20901 Carl F. Dees / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 9, 2009 Alexandria, VA Metropolitan Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 valo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Months Metastases to bone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed Days Terminal Delirium attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Ö 9 Unknown 9 Unknown is been signed by the should be detached ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 ☐ Yes 2 🖾 No certificate 2 7 No 1 □ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dopatient 2 □ ER/Outpatient 3 □ DOA After this c funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident hours after death. I Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Your.

Within 24 hours and.

To the Funeral Direct

Antely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065 485 Suparich Rem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Barbara Ann Supanich 31. Date filed (Month, Day, Year)

MAR 10

1500 Forest Glen Road, Silver Spring, MD 20910

| | | | For State Registrar | State | of Marylar | | artment of rtificate of | | | - | giene Reg. No. | 2000 | 09429 |
|---|--|--|---|---|---|-----------------------------------|---|-------------------------------|---|--|--|--------------------------|--|
| Ī | Physici | | 1. Decedent's Name (First, Mida Lolita | lle, Last) | Debo | ono | | | | 2. Date of De Month | ath | y Year | 3. Time of Death 6:30 A M |
| T | /Medic Examin | | 4a. Facility Name (If not institution Andrus House | | | | 4b. City, Town | , or Location Bethe | of Death | | | County of Dea | th |
| | Funeral Director | | 5. Social Security Number 474-74-4438 | 6. Sex 1 | 7. Age (In yrs. 89 | last birthday) Yrs. | If Under 1 Yea Months Day | | Min. J | 3. Date of Bir (Month, Da uly 28 | th ly, Year) 3,191 | 9. Bir | thplace (State or Foreign ountry) |
| | death with the Maryland ims 23a or 28a-f show r must be notified at | Director | Usual Residence of Decedent | | | | Bethesd 10f. Zip Code | | | | 10d. Inside City Limits 11≦ Yes 2 □ No 10g. Citizen of What Country? USA | | |
| IVIBITY IBING CILISTONOSO 4 2 should be filed within 72 hours after th and Mental Hygiene. 77 Is marked other than "natural", or he traumatic event, the Medical Examine | d by Funeral | 11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce | rried 12. Was De Armed F 1 ☐ Yes If Yes, G Year or | cedent Ever in U Forces? 2 🔯 No Give | | Was Decedent of f Yes, specity Co | f Hispanic Or uban, Mexica o Specify | | ify Yes or No ican, etc.) | | 14. Race - Am Black, Whi Specify: nd of Business | white | |
| | Completed | 15. Decede (Specify only high Elementary/Secondary (0-12) | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administr | | | | | | ind of work done during most of working O NOT use retired) Strative Assistant A | | | | |
| | To Be (| 17. Father's Name (First, Middle Archimede Ala | | | | | | er's Name (| First, Middle, oucke | , Maiden | Surname) | | |
| | | 19a. Informant's Name/Relation Troas Tselenti | | | Rue I | | aus #4 | 47, Bo | x 14, | 1050 | Bruss | els,Belgium | |
| Saitimore | permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once. | | 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 4 □ Donation 5 □ Other (| | n State | lumbia | sition (Name of natory or other p Gardens | Cem | | 0,09 | Arli | ngton, | |
| Dall | Depart Depart Import any inj | | 21. Signature of Eyneral Savice | Kelk | | 22 | | onsin | Ave., | NW., | Wash | | DC 20007 |
| Į | Physician /Medical Examiner | | 23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) | a. Cere | each line. brovascu o (or as a consec | ılar Ac quence of): | cident | lying, such as | s cardiac or | respiratory a | rrest, | | Approximate Interval Between Onset and Death 6 Months |
| la . | | al Examiner | Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Coronary Artery Disease Due to (or as a consequence of): Gastrointestinal Bleeding Due to (or as a consequence of): | | | | | | | 3 Years 2 Months | | | |
| .O. Box 68/ | death certifi e attending id for use as | hysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown | 1□Live | utcome pf pregn e birth 2 □ Feta gnant at time of c nown | aldeath 3□ | Ectopic pregnar | | | | | 23d. Date of de Month | elivery Day Year |
| ras, r | requires that the een signed by th nould be detache | by P | Part II. Other significant condit | _ | | - | nderlying cause (| given in Part | 1. | | | | o the cause of death? |
| Hec | The larate has | Completed | | | | | | | | 24a. Was autor perfo 1 Yes | | death? | |
| VItal | /sician: Th s certificate director, pag | To Be C | 25. Was case referred to medic examiner? 1 ☐ Yes 2☑ No | Hospital: | Inpatient 2 |]ER/Outpatien | t 3∏ DOA C | NAIL III III | | Check only o | ne) | 6 □Other (Spe | ecity) |
| IVISION OF | To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director, | Certification: T | 27. Manner of Death 1 X Natural 5 ☐ Pendi 2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could | ing (Mo | e of Injury onth, Day Year) | 28b. Time of Injury | 28c. In W M 1 | jury at /ork? □ Yes 2 □ |]No | 3d. Describe | how injur | y occurred | |
| Š | oltal or Att urs after d eral Direct illed in by | | 4 ☐ Homicide deter | mined 286. Flac | ce of injury - At h ding, etc. (Speci | | | | | City or To | wn, State |) | tural Route Number, |
| | the Hos | l edical | (Check only 2 ☐ Medica one) | | | | vestigation, in m | y opinion, de | | d at the time, | date and | d place, and du | e to the cause(s) |
| | 2}25 8 | M | 29b. Signature and title of certifi | er Le Zi | mm K | 20 | 29C. Lice | nse number D | C 167 | | | e signed (Mon | |
| | - | | 30. Name and address of person Lawrence Zimn | _ | | | | 302, W | ashin | gton. | DC 2 | 0037 | |
| d | Sta Registr | | 31 Date filed (Month Day Vest | | Registrar's Sign | aturo | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| an | 1. Decedent's Name (First, Middle, | ARIE | DELOZ | IER | | 2. Date of Death | Day Year | 3. Time of Death | | |
|---|---|--|--|---|--|--|--|--|--|--|
| cal ner | 4a. Facility Name (If not institution, | give street and number) | | | r Location of Death | 03 | 4c. County of De | 1 0 (1) | | |
| | Anne Arunde | | | Annapo1 | | | Anne Ar | undel | | |
| | 220-62-5069 | | e (In yrs. last birth | day) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, Decembe | ^{year)} r 14,1953 | irthplace (State or Forei Country) England | | |
| | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limit | | |
| tiffied | Maryland St. 1 | Mary's | Mech | anicsville | | | | 1 □Yes 2 X N | | |
| Funeral Director | 10e. Street and Number 29730 Allison Circle | | | 10f. Zip Code 20 | 659 | 10 | 10g. Citizen of What Country? USA | | | |
| ρ | 11. Marital Status 1 Never Married 2 Marrie 3 Married 4 Divorced | 12. Was Decedent Armed Force 1 Yes 2 1 If Yes, Give Year or Dates: | | 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ▼ No Specify: | | | Black, Wh | - American Indian, k, White, etc. White | | |
| any Injury or other traumatic event, the Madical Examins's name to notified at once. To Be Completed by Funeral Director | 15. Decedent's (Specify only highest | (| Decedent's Usual Occur Give kind of work done | during most of worki | ing | 16b. Kind of Business/Industry Hall | | | | |
| | Elementary/Secondary (0-12) | 5 ^{ollege (1-4or 5} | | life. DO NOT use retire rtified Nur | | • | Charlotte | Veterans E | | |
| Be | 17. Father's Name (First, Middle, L | | 1 | | 18. Mother's Name | e (First, Middle, M y Gianas | | | | |
| To | 19a. Informant's Name/Relationsh Shannon M. De | | 00: | Mailing Address (Street | | | | | | |
| | 20a. Method of Disposition | | 20b. Place of I | Disposition (Name of crematory or other pla | | - 1 | 20c. Location - City of | or Town, State | | |
| | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | Brinsi | ield-Echols | | arch - 2009 | Charlotte | Hall, MD | | |
| | 21. Signature of Funeral Service L | | MOO817 | | | | Echols F. | H., P.A., 1, MD 2062 | | |
| | 23a. Part 1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) | _a | d the death. Do not ne. | mela | that u | or respiratory arro | est, lent | Approximate Interval Between Onset and Death | | |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c. | | | | | | | | | |
| cal Exar | Due to (or as a consequence of): | | | | | | | | | |
| | | | | | | 23d. Date of delivery Month Day Year | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No | 4 ☐ Pregnant a | 2 Fetal death | 3 ☐ Ectopic pregnan 5 ☐ Other (specify) | су | | | and the same of th | | |
| Physician/Medical | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 ☐ Fetal death at time of death | 5 ☐ Other (specify) | | 220 Did tol | Month | Day Year | | |
| by Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 ☐ Fetal death at time of death | 5 ☐ Other (specify) | | | Month pacco use contribute | Day Year to the cause of death? | | |
| by Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 ☐ Fetal death at time of death | 5 ☐ Other (specify) | | 1 ☐ Ye | Month pacco use contribute ps 24 No 3 ry ry ry ry ry ry ry ry ry r | Day Year to the cause of death? Probably 4 ☐ Unknow autopsy findings availa o completion of cause of | | |
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| | | 1 _ State | | artment of Health | | | 200 | 9 1191.31 | |
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| | | Registrar 1. Decedent's Name (First, Middle, Last) | | inicate of Deat | | Reg. N | o. <u>Z</u> 0 0 | 3. Time of Death | |
| Physi /Med | ician dical | WILLIAM THOMAS DUFFEY | | | | March | 12 200 | 09 1:50 P M | |
| Exam | niner | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location | | 4 | c. County of De | | |
| Funera | al | WASHINGTON COUNTY HOSPITAL 5. Social Security Number 6. Sex 7. Age (II | n yrs. last birthday) | If Under 1 Year If Und | RSTOWN der 24 Hrs. 8 | . Date of Birth (Month, Day, Year | | NGTON rthplace (State or Foreign | |
| Directo | _ | 220-18-2218 1™ 2□ F 82 | Yrs. | Months Days Hour | rs Min. | MAY 10, 1 | 926 | ountry) MARYLAND | |
| fand ow | | Usual Residence of Decedent 10a. State 10b. County 10 | c. City, Town or Lo | cation | | | | 10d. Inside City Limits | |
| e Mary ka-fsh tiff d | cto | MARYLAND WASHINGTON | | BOONS | BORO | | | 1 ☐ Yes 2 No | |
| vith the | Directo | 10e. Street and Number | | 10f. Zip Code | | 10g. C | itizen of What C | * | |
| heath v | Funeral | 7929 A3 OLD NATIONAL PIKE 11. Marital Status 12. Was Decedent Evel | rin U.S. 13. V | 2171. | | fv Yes or No- | 14. Race - Am | S.A. | |
| after c | | Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give | 1943- | Was Decedent of Hispanic f Yes, specify Cuban, Mexi 1 □ Yes 2 ∑ No <i>Sp</i> ec | | can, etc.) | Black, Whi | | |
| ifice X 1 X 1 3-UU30 be filled within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinationals. | of pe | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | 1946 | - | у. | | | WHITE | |
| 2 L D | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give | dent's Usual Occupation kind of work done during m DO NOT use retired) | nost of working | 166.1 | Kind of Business | /Industry | |
| filed within Hygiene. | Com | 9 | | TRUCK DRIVE | R | E | UEL OII | DISTRIBUTOR | |
| aryiano 2 2 should be filed and Mental Hygi Is marked other aumatic event, I. | Be | 17. Father's Name (First, Middle, Last) OTHO DUFFEY | | | other's Name <i>(F</i> CE SUMM | First, Middle, Maide FDS | n Surname) | | |
| re, Maryle s 1 and 2 should f Health and Mer item 27 Is marke other traumatic | 2 | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailin | ng Address (Street and Nur | | | or Town, State, | Zip Code) | |
| and 2 lealth a m 27 ls | | WAYNE DUFFEY/SON | 1 | A10 OLD NATIO | | | | | |
| J 90 | | 20a. Method of Disposition 2 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | 20b. Place of Dispos cemetery, crem | sition (Name of natory or other place) | Date | e 20c. l | ocation - City o | Town, State | |
| permit. Page Department of Important: If any injury or | aŭ | 4 □ Dopation 5 □ Other (Specify) 21. Signature of Jungral Service Licensee | | Name and Address of Fac | | | ERSTOWN | , MARYLAND | |
| and Dep | | | Dogn | 506_Old Natio | DAST | -STAUFFER | | | |
| | | 23a. Part 1. Enter the disease, if complications that caused the shock, or heart failure. List only one cause on each line. | | | | | boro, ii | Approximate Interval Between | |
| Physiciar /Medica | | Immediate Cause (Final disease or condition resulting in death) | 2016/ | Failure | | | | Onset and Death | |
| Examine | | Due to (or as a co | nsequence of): Bayel | OBS COL | 7200 | | | | |
| it d | ner | Sequentially list conditions | | | | | | | |
| xecute and I-trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co | 24+1+1 | 5 | | | | | |
| cate be executed only sician and the burlal-transit | | d d | nisequence ory. | | | | | | |
| rtificate | Medi | IF FEMALE: | | | | | | | |
| eath certific attending p | lan/I | 23b. Was decedent pregnant 23c. If yes, outcome of p | | | 23d. Date of de | livery Day Year | | | |
| The law requires that the death certific at has been signed by the attending page 2 should be detached for use as I | Physician/Medical | 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at tim 9 ☐ Unknown 9 ☐ Unknown | e of death 5 □ | Other (specify) | | | Month | Day Tour | |
| s that gned t | by PI | Part II. Other significant conditions contributing to death but no | ot resulting in the un | derlying cause given in Par | rt I. | 23e. Did tobacco | use contribute t | the cause of death? | |
| w requires to be signal should be | ted | 1400 0 11438 (63 | Melli | 775 | | 1 □ Yes 2 | ☑No 3□P | robably 4 🗍 Unknown | |
| The law te has t | Completed | Carray Anery Die | Jeese | | | 24a. Was an autopsy performed? | 24b. Were a prior to death? | utopsy findings available completion of cause of | |
| | a) | 25. Was dase referred to medical examiner? | - | 26 Pla | ace of Death (C | 1 ☐ Yes 2 ☑ No | 1 ☐ Yes | 2 □No | |
| hysici this cer al direc | To B | HOSDIA: | 2 ER/Outpatient | Othor | | 5 ☐ Residence | 6 ☐ Other (Spe | ecify) | |
| Attending Physician; r death. sctor: After this certifica by the funeral director, p | ion: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Ye) Matter of Injury (Month, Day, Ye) | ar) 28b. Time of Injury | 28c. Injury at Work? | | . Describe how inju | ry occurred | | |
| Atten r deatl ector: by the | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. | At home, farm, stre | 12100 - | | Location (Street a | nd Number or R | ural Route Number. | |
| ital or rrs afte ral Dir | Cert | 4 Dillaing, etc. (S | | | | City or Town, State | e) | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | edical | 29a. Certifier 1 ☐ Certifying Physician: To the best of my (Check only one) 2 ☐ Medical Examiner: On the basis of examiner and manner stated. | y knowledge, death amination and/or inv | occurred at the time, date restigation, in my opinion, o | and place, and death occurred | due to the cause(s at the time, date an | s) and manner a d place, and du | s stated. e to the cause(s) | |
| To the within To the comple | Me | 29b. Signature and title of certifier | | 29c. License numbe | er | 29d. Da | te signed (Mon | h, Day, Year) | |
| | | June & Dereveld | | 10061 | 117 | MA: | RCH | 3, 2009 | |
| W-8+1 | | 30. Name and address of person who completed cause of death | (Item 23a) (Type, P | Print) 251 E | · MT | MA | SI | ^ | |
| Si | tate | 31. Date filed (Month, Day, Year) 32. Registrar's 5 | Signature | 17-09-85T | our | (VI) | 2114 | 0 | |
| Regis | | MAR 1 6 2009 | - B. A | add | | | | | |
| HMH 17 Rev 1/ | /2001 | | | | | | | | |

09

| -02044 Ilerie Duvall | | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | | | | | | | | | |
|---|----------------|---|--------------------|--|--------------------------------|----------------------|--------|-------------------|-----------------------------|-------------------------------------|-----------------------------|--|-------------|----------------------------------|---------|
| | | 1- For State Certificate of Death | | | | | | | | | | Reg. No. 2009 094 (| | | |
| Physicia edical Examin | | | | | | | | | Month Day March 12, 2009 | | | | me of Death | | |
| | | 4a. Facility Name (if not institution, g | 4 | 4b. City, Town, or Location of Death | | | | | 4c. C | 4c. County of Death, | | | | | |
| | | Union Hospital | | | | Elkton | | F-23 | | | Ce | | - | | |
| Funeral Director | | 5. Social Security Number 6. \$ 221-82-2996 | birthday) | If Under 1 Year If Under 24Hrs Months Days Hours Min. | | | | 8. Date of Bir | | Fo | preign | DE | | | |
| | | Usual Residence of Decedent | M 2 F | 17 | Yrs. | | | | | геви | uary 14, 1992 Country) DE | | | | |
| any | | 10a. State 10b. County | | | own or Location | | | _ | | | | | | I. Inside City | |
| and f show | 5 | DE New C | astle | Ne | w Castle | | | | | | | | | Yes 2 | No |
| after death with the Maryland al", or items 23a or 28a-f show any iner must be notified at once. | Director | 10e. Street and Number 700 Clark St. | | | | 10f. Zip Cod 1972 | | | | 1 | | n of What o | Country? | , | |
| ≥ 5 ≤ | | 11. Marital Status | A | cedent Ever in U.S. | | Decedent of | | | | | - 14 | | | Indian, Black | , |
| r death or ite | Funeral | 1 Never Married 2 Marrie | 1 Yes | 2 No | | es, specify Cul | | | Puerto Ri | o Rican, etc.) White, et | | | | /hite | |
| rs afte | اھ. | Widowed 4 Divorce Decedent's Education (Specify of the content of the co | d If Yes, Give Yes | | 16a. Decedent | Yes 2 X | | | nd of wor | Specify of work done 16b. Kind of I | | | | | |
| 2 hou | eted | Elementary/Secondary (0-12) | | 1-4 or 5+) | | st of working | | | | | | * 1 # | * 4/4 | · | |
| 036 ithin 7 one. r than | Completed | Student Ed | | | | | | | Educati | on | | | | | |
| MD 21215-0036 2 should be filed within 72 hours h and Mental Hygiene. 27 is marked other than "natur martic event, the Medical Exam | | 17. Father's Name (First, Middle, Las | t) | | | | 18 | | | irst, Middle, I | Maiden Su | rname) | | | |
| 212' ild be Mental marke | To Be | Douglas Wall 19a. Informant's Name/Relationship (| Type, Print) | | 19b. Mailing | Address (S | treet | | | n Duvall | nher City | or Town S | State Zin | Code) | |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. faut: If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner must | | Ray T.Duvall/Brothe | | | 10 | Clark St., | | | | | ibor, on | 0. 10111, 0 | rato, zap | 0000) | |
| re, reginal land | | 20a. Method of Disposition 1 Burial 2 Cremation 3 | Removal f | I | ce of Disposi matory or oth | | ceme | etery, | [| Date | 20c. Lo | cation - Cit | y or Tow | n, State | |
| altimore, mit., Pages I ar partment of Her portant: If ite | | 4 Donation 5 Other Specif | y: | OIII State | racelawn | | Par | k | Mar | ch 19, 2009 | ; | New 0 | Castle | , DE | |
| Baltim permit, Pag Department Important: injury or or | | 2 Signature of Funeral Service Lice | ensee | | | ame and Addr | | | | | | | | 115 | 1001 |
| Physician | 4 | 23a. Part Y. Enter the disease, or com | plications that o | aused the death. De | | andrew G | | | | | | | | n, MD 2 | |
| /Medical | | failure. List only one cause on e | each line. | done into | | | | | | | | | В | etween Onse Death | et and |
| xaminer | | or condition resulting in death) | | consequence of): | DAICAL. | LOII | | | -3.74 | | | | | | |
| | _ | Sequentially list conditions, if any, leading to immediate | Due to (or as | a consequence of): | | | | | | | | | | | |
| | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated | | | | | | | | | | | | | |
| ted 1 1 1 1 1 1 1 | Exa | events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | | | |
| cords, P.O. Box 68760, Iaw requires that the death certificate be executed has been signed by the attending physician and 2.2 should be detached for use as the burial - transit | ical | X UNPENDED | AMENDED | 23a,27,28 | Ba-f, j | perME, | g8 | 89 3 | /26/ | 09 TT | | | | | |
| 68760, certificate be miding physicilise as the buri | Med | IF FEMALE: | 23c. If yes, | outcome of pregnar | ncy | | - | | | | 23d. I | Date of del | ivery | | |
| 68 certifi | ian/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live I | oirth nant at time of death | , = = | al death | 3 | Ectopic | pregnanc | egnancy Month Day | | | Yea | ar | |
| Box 68760, starth certificate be the attending physical for use as the buring for use as the buring of the use as the use as | Physician/Medi | 1 Yes 2 No 9 V Unknow | 7 | | o Oth | er (Specify) | _ | | | | | | | | |
| P.O. s that the gned by t | by PI | Part II. Other significant conditions | contributing t | o death but not resu | alting in the ur | nderlying caus | se giv | en in Part | t I. | | | | | ause of deat | |
| ls, F | | | | | | | | | _ | 1 Yes | | CONTRACTOR AND ADDRESS OF THE PARTY AND ADDRES | | 4 Unkr | |
| ord law rec has bee | ple | | | | | | | | | 24a. Was autop | | | to comp | y findings ava letion of caus | |
| tal Rec cian: The certificate ector, page | Completed | | | | | | | | | 1 🗸 Yes | | | Yes | 2 1 | No |
| Vital Rec ysician: The I his certificate I director, page | Be | 25. Was case referred to medical examiner? | Hospital: | Inpatient 2 ✓ Ef | R/Outpatient | - | | of Death (Cothern | Nursing I | | Residenc | e 6 C | Other: | | |
| of Virging Physical After this neral direction | 5 | 1 ✓ Yes 2 No 27. Manner of Death | 28a. Date | | 8b. Time of In | | | at Work? | | Bd. Describe | | | - | | |
| ion tendir leath tor: A | aţio | Natural 5 Pending Accident Investiga | ר גיו | | Fd 12:0 | 00 nm ¹ | Ye | s 2 X | No u | nk | | | | | |
| Division of Vital Records, ral or attending Physician: The law requires after death al Director: After this certificate has been sited in by the funeral director, page 2 should the | Certification: | 3 Suicide 6 X Could no | t be 28e. Plac | Found: si | e, farm, stree ingle | | ce bui | ilding, etc. | . 28 | Sf. Location (S or Town, S | itate) | | | | r, City |
| Division of \ To the Hospital or Attending Phywifin 24 hours after death To the Funeral Director: After the completely filled in by the funeral | | 4 Homicide determine | (Specify) | residenc | ce | | | | 19 | 5 Red | hill | | | n, MD | |
| the II thin 24 the Fi | Medical | To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | use(s) | | | | |
| To Viri | Me | 29b. Signature and title of certifier | and manner s | stated. | - · · · · · | 29c. Lic | ense | number | | | 29d. Da | ite signed | (Month, l | Day, Year) | |
| | | Carol | 400 | Doan | | 0. | C.M | .E. | | | March | 13, 200 | 09 | | |
| | 1 | 30. Name and address of person who | | , | | tract D=" | im - | no MAD | 24204 | | | | | | |
| | - 1 | Carol Allan, MD Assist | arit iviedical | Examiner 1 | II renn S | oreet, Bait | 111101 | E, IVID | ∠ ∠U`l | | | | | | |

State 31. Date filed (Month, Day, Year)
Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Bernard Degrange March 2009 9:05 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick 8. Date of Birth (Month, Day, Year) June 12, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ₹M 2 ☐ F 220-42-5475 1947 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 East 5th Street 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ₩XNever Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes XXNo Specify: Completed by Specify: White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Bakerv es 1 and 2 should be filed wi of Health and Mental Hygier of tem 27 is marked other th or other traumatic event, the 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harlen W. DeGrange Sadie Hurst 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Tina M. Houck, niece 9403 Opossumtown Pike, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H int: If ite permit. Page Department o Important: If any Injury or once. XX Burial 2 Cremation 3 Removal from State Union Chapel Cemetery Mar. 23, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Puneral Service Licersee ²² Name and Address of Facility Reeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DAY /Medical Due to (or as a consequence of): Examiner BRAIN UNKNOWN Sequentially list conditions if any cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burlal-trar resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **À** MASS 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒Ño autopsy certificate 2 2 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📈 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division of Vital Records, P.O. Box 68760, 24 hours a within 2

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Florin Rusu, M.D., 400 West Seventh Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 22. Registrar's Signature

alin

State Registrar

MAR 2 5 2009

29b. Signature and title of certifier

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician DelSignore Kathleen 03 15 09 0125 Freda /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CUMBERLAND ALLEGANY WMHS BRADDOCK CAMPUS Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Apr 11, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months Days Hours 1 □ M 2 □ ₽ 1926 218-30-0565 82 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show id other than "natural", or items 23a or 28a-f shovevent, the Medical Examinat must be notified at Allegany Cresaptown 1 □Yes 2 □ No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 14002 Cedarwood Dr. SW Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 → Married 1 □ Yes 2 □ **X**o altimore, Maryland 21215-0036 Specify: Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than **YMCA** Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Health and Mental I Important; If Item 27 is marked of Corinne Steckman George Dewey Deffinbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Frank DelSignore husband 14002 Cedar Wood Dr. Cresaptown 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or SS Peter and Paul Cemetery 3/18/2009 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner ONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) burialng physician a P.O. Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) the 8 detached 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 2 100 Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day, Year) 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 24 hours after death e Funeral Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 0

State Registrar

DHMH 17 Rev 1/2001

DK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221

32. Registrar's Signature

D0054004

HIghway

09

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

| | | | 1 - State of Maryland / | | rtment of F tificate of I | | and Me | ntal H | ygiene (Reg. No. | 2009 | 09 | 435 |
|----------------|--|-------------------------|--|--------------|---|-------------------|--------------|--------------------------|--|----------------------|------------------|-----------------------|
| | Physici | an | 1. Decedent's Name (First, Middle, Last) | | | | | Date of D | | Year | 3. Time o | |
| | /Medic Examin | cal | IRMA JANE EURE 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | | | MARGE | | 2009 County of Dea | | A ^M |
| | | | WILLIAM HILL HEALTH CARE 5. Social Security Number 6. Sex 7. Age (In yrs. last | hirthday) | EA If Under 1 Year | STON | 24 Hrs. 8 | Date of F | lirth | TALB | thplace (State | or Foreign |
| | Funeral Director | | 217-54-5868 1 M 2X F 61 | Yrs. | Months Days | Hours | Min. F | (Month, I | Sirth Day, Yea <i>r)</i> 24, 19 | 00 | MARYLAN | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, To | own or Loc | ation | | | | | · | 10d. Inside C | ity Limits |
| | r 28a-f show | tor | | YAL C | AK | | | | | | | 2 X No |
| | or 28s | Director | 10e. Street and Number | | 10f. Zip Code | | | | 10g. Citize | en of What Co | ountry? | |
| | ter death with titems 23a or | Funeral | 7039 THORNTON ROAD 11. Marital Status 12. Was Decedent Ever in U.S. | 13 W | /as Decedent of H | .662 | gin? (Sneci | fv Yes or N | lo- 14 | USA 4. Race - Ame | erican Indian | |
| 36 | hours after death with the Maryland tural", or items 23a or 28a-f show all Exercions coust be coulfind at | by Fun | 11. Marital Status 1 Never Married 2 Married Forces? 1 Never Married 2 Married Forces? 1 Yes 2 No If Yes, Give Year or Dates: | If | Yes, specify Cuba ☐Yes 2 X No | Specify: | , Puerto Ri | can, etc.) | | Black, White | | |
| 5-0036 | nin 72 hours afte e. In "natural", or i V. dien Lever, i | | 15. Decedent's Education | 6a. Deced | ent's Usual Occup | ation | t of working | | 16b. Kind | d of Business | /Industry | |
| 121 | within 72 ene. than "na | ompleted | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | life. D | O NOT use retired | d) - | or working | | CHOD | e nest | क्या ८४८क | ne m |
| 2 | filed Hygi Sther | C | 12 -0- | DATE | ENTRY C | | er's Name (i | First, Midd | le, Maiden S | | TH SYST | <u>em</u> |
| Maryland | e d the | To B | NOBLE STEWART EURE | | | | JESSI | E HAI | L | | | |
| /ar/ | 2 series | ľ | | | g Address (Street | | | | | | | |
| | 1 and Health tem 27 | | 20a Method of Disposition 20b. Place | of Dispos | IINE PIN | ı, | H KUA Dat | | | ation - City or | | |
| altimore, | 0 ° | | 1 TRurial 2 Cromotion 2 Removal from State Come | | atory or other place L CEMETE | | 3-10- | 2009 | E | ASTON, | MD 216 | 01 |
| Balti | permit. Pag Department Important: I any injury o | | 21. Signature of Funeral Service Licensee TOHN R. MERLERON | FE | Name and Addres LLOWS, HE OS. HAR | LFENB. | EIN & | NEWNA | M FUNE | ERAL HO | DME, P. | A. |
| | death certificate be executed Wax Wax Wax Wax Wax Wax Wax Wa | sician/Medical Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. Description of pregnant in the cause of the death. Description of pregnant is shown on the cause of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) IF FEMALE: 23b. Was decedent pregnant in the cause of pregnancy in the cause of the cau | ce of): | W/dely | mel | | | Brea | ∂d. Date of de | livery | tween Death |
|). O | y th | Physicia | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | Other (specify) | | | | | Month | Day | Year |
| S, | requires that been signed b hould be deta | ρ | Part II. Other significant conditions contributing to death but not resulti | g in the un | derlying cause giv | en in Part I. | tion | | d tobacco us ∃Yes 2 X | | o the cause of o | |
| 000 | w requ | ompleted | | | | | | 24a. Wa | Ī | • | utopsy findings | available |
| ž | The law cate has b page 2 sl | dwo | | | | | | aut per 1 ∐ Yes | topsy rformed? 2 No | prior to death? | completion of o | ause of |
| Vital Records, | sician: The lav certificate has rector, page 2 | Be C | 25. Was case referred to medical examiner? | | | | of Death (| | | 1,00 | | |
| <u></u> | Physician: r this certific ral director, I | <u>د</u> | 1 | Outpatien | t 3 ☐ DOA Oth 28c. Injur | 4 LIM | | | esidence 6 e how injury | Other (Spe | ecify) | |
| 0 | Attending or death. ector: Afte by the fune | atior | 1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) 2 ☐ Accident investigation | Injury | Worl | kí? Yes 2. [□ | | | | | | |
| Division | or Atte | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify) | , farm, stre | et, factory, office | | 28 | f. Location City or T | (Street and own, State) | Number or R | ural Route Nur | nber, |
| _ | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | edical Ce | 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination | | | | | | | | | s) |
| | o the i | Medi | one) and manner stated. 29b. Signature and title of certifier | | 29c. Licens | se number | | | 29d. Date | signęd (Mon | th, Day, Year) | |
| À | TLS | | Mussell a Sey | | 3 4 1 | 1258 | () | | 3/4 | 1/09 | | |
| | 12 | | 30. Name and address of person who completed cause of death (Item 23 Section 1997) Section 1997 | (Type, F | Suwoo | d R | SV E | Eas7 | on in | 02 | 1601 | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) MAR 0 5 2009 32. Registrar's Signature | 40 | Med | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

3. Time of Death

7:30A

Birthplace (State or Foreign
Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

1 ☐Yes 2 ☑No

performed'

28d. Describe how injury occurred F-9

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10276 Southern Mary and BLVU Dun KITK

3/11/2009

29d. Date signed (Month, Day, Year)

Other: 4XXNursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Year

1 □Yes 2√No

Virginia

White

Division of Vital Records,

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours and co...

To the Funeral Director; Aff

To the Funeral Director; Aff

Be

Certification: To

Medical

DB38 State

31. Date filed (Month, Day, Year)

Bahram Pishdad MD

and title of certifier

30. Name and address of person who

5 Pending

investigation

determined

6 ☐ Could not be

25. Was case referred to medical

1 Yes 2 No

27. Manner of Death

1 Natural

2XAccident

3 ☐ Suicide

29a. Certifier

29b. Signaty

4 Homicide

(Check only one)

1328 Southern Ave SE # 310 Washington DC 20032 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

February 12, 209 UNFM 1E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MOG

28b. Time of

Injury

38c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D51520

29c. License number

1 ☐ Yes

28a. Date of Injury (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Cassandra Denise Edelen 03--3-2009 /Medical 00:18 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Clinton
If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Prince Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) **Funeral** Days 1 □ M 2**X**□ F Months Hours Min Director 37 217-08-6239 05-26-71 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 X Yes 2 No Charles Maryland Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3432 Ryon Ct 20601 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2x No Specify Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Asst. Wal-Mart 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph W. Edelen Sr traumatic Ruth Ann Washington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If Item 27 is any Injury or other traus Lisa Edelen / Sister 8806 Hardest Dr. Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 3/9/09 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 191 23a. Part1. Enter the risease, or complications that cau'ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) MeTESTE /Medical Due to (or as a consequence of) Examiner RCINO Sequentially list conditions, if any, i.e. in a limit list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner pital or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burnal-transit filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1988 02-04-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern Auc SEm1) Date filed (Month, Day, Year) Registrar's Signature State parke

DHMH 17 Rev 1/2001

Registrar

MAR 112009

Maryland

Baltimore,

Box 68760.

P.O.

of Vital Records,

Division

Pereus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 7, **Physician 2**009 7:55P. M Ramsdell Frank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 3114 Gracefield Road, WC412 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months June 30, 1922 1 □ M 2 F 579-22-0181 86 Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Martical Exprandum mant the martine. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring 1 □ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 3114 Gracefield Road, WC412 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hobart Ramsdell Josephine Boland ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11302 Odell Farms Court Beltsville, Maryland 20705 Justin X. Frank -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State St. Rose of Lima Cemetery 3/11/2009 Gaithersburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Squamous Cell Carcinoma Face Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ipital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 X No 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Breast Carcinoma; Cerebrovascular Accident 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

E.S.Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 10 2009

D24035

March 9, 2009

| | · | | For State Registrar | | - | Certificate | | Death | Re | g. No. 200 | 9 09439 |
|--|---|-----------------|---|---|-----------------------|--|-----------------|---|--|---------------------------------------|---|
| | Physicia | | 1. Decedent's Name (First, Middle Helen Lois I | | | | | , | 2. Date of Death Month March | | 3. Time of Death 6:15 p M |
| | /Medic | | 4a. Facility Name (If not institution | n, give street and number) | | 1 | | Location of Death | | 4c. County of D | |
| | | | Carroll Hospi | | e (In yrs. last birt | | | tminster If Under 24 Hrs. | 8 Date of Birth | | roll |
| | Funeral Director | | 218-26-4070 Usual Residence of Decedent | 1 M 2 🔀 F | | | Days | Hours Min. | 8. Date of Birth (Month, Day, Mar 21 | 1929 | Birthplace (State or Foreign Country) MD |
| aryland | show | - | 10a. State 10b. County | rroll | 10c. City, Town | or Location | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| he Mg | 28a-f | Director | MD Ca: | TIOIT | 1100 | 10f. Zip (| | | 10 | g. Citizen of What | |
| th with t | 23a or | al Dir | 799 Kent Ter | race | | | 21 | 157 | | USA | . Godiniy. |
| be filed within 72 hours after death with the Maryland | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Marical Examinat must be rediffed at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Marr | I If Yes, Give | | 13. Was Decede If Yes, specif 1 ☐ Yes 2. | | lispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | American Indian, Vhite, etc. White |
| 2 hours aff | atural' cal Ev | | 3 ☑ Widowed 4 ☐ Divorced | nt's Education | 16a. | Decedent's Usual | | | . 1 | 6b. Kind of Busine | |
| thin 72 | ne. nam "na i Medii | Completed | (Specify only highe Elementary/Secondary (0-12) | College (1-4or 5 | +) | life. DO NOT use | retired | | ing | miss 127 | or some Const. |
| iled w | Hygier ther th | | 12 17. Father's Name (First, Middle, | l ast) | | Custom | er ; | Service 18. Mother's Name | e (First, Middle, M | | ower Cart |
| ld be file | fental rked or tic eve | To Be | John Rasch | | | | | | ude Hei | · | |
| IVICAL y | Ith and N 27 is ma rraumar | | 19a. Informant's Name/Relations J. Carey Sulliv | | 19b. | Mailing Address (| | and Number or Run | al Route Number, stminste | | te, Zip Code) 1157 |
| es tar | of Hea item | | 20a. Method of Disposition | - | 20b. Place of cemeter | Disposition (Name y, crematory or oth | e of er plac | ce) 03/0 ^t | 9 / 2009 2 | 0c. Location - City | or Town, State |
| Dermit. Pages | tment tant: It jury o | | 1 ☐ Buriał 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S | Specify) | Carrol | 1 Cremat | | | | Hampstea | |
| permi | Depar Impor any in once. | | 21. Signature of Functor Service | Licensee | | | | erti Mome gton Road | | | |
| | | | 236. Part 1. Enter the disease of | r complications that caused tonly one cause on each lin | the death. Do r | 1 | | | | | Approximate Interval Between |
| Ph | ysician | | Immediate Cause (Final disease or condition | E | ND S | SAKE | | DEMON | MA | | Onset and Death |
| | Medical aminer | | resulting in death) | Due to (or as | a consequence o | of): | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b | a consequence o | of): | | | | | |
| ecuted | and -transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | C | a consequence of | -A- | | | | | |
| do rou, tificate be executed | ig physician and as the burial-transit | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Due to (or as | a consequence o | 51). | | | | | |
| rtificat | ng p hy as the | l edical | IS SEALUE | u | | | | | | | |
| the death cer | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use. | ysician/N | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal death | 3 ☐ Ectopic pre 5 ☐ Other (spe | | y | | 23d. Date of Month | f delivery Day Year |
| uires that t | within 24 hours arter death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached. | d by Phys | Part II. Other significant conditi | ions contributing to death b | ut not resulting in | the underlying ca | use giv | en in Part I. | | | te to the cause of death? ☐ Probably 4 ☐ Unknown |
| he law requires t | has beer e 2 shou | Completed | | | | | | | 24a. Was an | prior | e autopsy findings available |
| ician: The | ficate or, pag | | 25. Was case referred to medica | i I | | | | | | □ N6 1□ | Yes 2 No |
| ysicia | is cert | To Be | examiner? | Hospital: | ent 2 🗆 ER/Ou | tpatient 3 DO | Oth | or: | h <i>(Chec</i> k o <i>nly</i> o <i>ne</i> ome 5□ Reside | | Specify) DOVE HOUS |
| ng Phy | offer th | on:T | 27. Manuel of Death 1 ☐ Natural 5 ☐ Pendir | 28a. Date of Inju (Month, Da | ry 28b. 1 | njury | c. Injur Wor | ry at k? | 28d. Describe how | | -, |
| Attending | death. ctor: A y the fu | ficati | 2 ☐ Accident investi | not be | urv - At home, fa | rm, street, factory, | | Yes 2□No | 28f. Location (Str. | eet and Number o | or Rural Route Number, |
| oital or / | urs after ral Dire Illed in b | Certification: | 4 Homicide determ | building, etc | c. (Specify) | | | | City or Town, | State) | |
| he Hosp | in 24 ho he Fune pletely fi | Medical | 29a. Certifier 1 ☐ Certifyii (Check only one) 2 ☐ Medical | ng Physician: To the best I Examiner: On the basis o and manner sta | f examination an | e, death occurred and/or investigation, | it the ti | me, date and place, opinion, death occur | and due to the carred at the time, da | use(s) and manne te and place, and | er as stated. due to the cause(s) |
| ر ا | | Ž | 29b. Signature and title of certifie | Kull | MD | 29c. | Licens | se number 5397 | 3 (| d. Date signed (M | nonth, Day, Year) |
| , , | 4 | | 30. Name and address of person | who completed cause of d | eath (Item 23a) | Joshan | - - | WESHINS | ter un | 21157 | 1 |
| | Sta | ite | 31. Date filed (Month, Day, Year) | | ar's Signature | SE STICE | <u> </u> | MINIE | A LINE | | |
| DUMU | Registr | ar | MAR. | 12 2009 Ken | wa p | . Sparks | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | - | For State Registrar | | State | of Ma | aryland | - | rtment of tificate | | | | Mental H | | ne No. 20 | 09 | 09440 |
|--|------------------|--|----------------------------------|---|-------------------------------------|---------------------------------------|--------------------------------|---|----------------------------------|-----------------------|--------------------------|-----------------------------------|---------------------|--------------------------|-------------------------|---|
| Physicia | | 1. Decedent's Name | e (First, Middle MARIE | | | | | | | | | 2. Date of I Month MARCH | | Day 20 | Year 09 | 3. Time of Death 21:07 Р м |
| /Medic Examine | | 4a. Facility Name (/ | f not institution | n, give street and | | | | 4b. City, To | | | of Death | | | 4c. County | | |
| Funeral | | 5. Social Security N | lumber | 6. Sex | 7. Ag | je (In yrs. la | ast birthday) | If Under 1 Months D | - | | r 24 Hrs. Min. | 8. Date of (Month, | Birth Day, Yea | ar) | 9. Birth Cou | place (State or Foreign ntry) |
| Director | | 212-58-80 Usual Residence of | | | | 58 | Yrs. | | | | | DECEMBE | R 10, | , 1950 | MAR | YLAND |
| hours after death with the Maryland tural", or items 23a or 28a-f show al Exarriner is ust be in titled at | 7 | 10a. State | 10b. County | | | | , Town or Lo | | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 No |
| vith the Maryle or 28a-f sho | Director | MARYLAND 10e. Street and Nur | | ANNE'S | | C | HESTE | 10f. Zip Co | ode | _ | | | 10g. | Citizen of \ | What Cou | |
| th with 23a or | | 101 BUF | FLEHEAI | COURT | | | | 216 | | | | | | ITED | STAT | ES |
| er dea items | Funeral | 11. Marital Status | O - M | Armed | ecedent Forces? | | 3. 13. | Nas Deceder f Yes, specify | nt of His Cubai | spanic C n, Mexic | rigin? (Sp an, Puerto | pecify Yes or Rican, etc.) | No- | | e - Ameri ck, White, | ican Indian, etc. |
| urs aft al', or Exami | þ | 1 X Never Marri 3 ☐ Widowed | | If Yes, | Give r Dates: | NO | | 1∐Yes 2 X | No | Specif | y: | | | Specif | WHI | TE |
| na na | Completed | (Spec | 15. Deceden | t's Education st grade complete | ed) | | (Give | dent's Usual (kind of work of DO NOT use | done d | lurina mo | st of work | king | 16b | Kind of B | usiness/Ir | ndustry |
| filed within Hygiene. other than " | omp | Elementary/Seco | ondary (0-12) | College | e (1-4or 5 | 5+) | | DRIVE | , | , | | | TF | RANSPO | ORTAI | CION |
| be filed vertal Hygin | BeC | 17. Father's Name | (First, Middle, | Last) | | | | · | | 18. Mot | her's Nam | ne (First, Midd | ile, Maic | len Surnan | ne) | |
| hould be Men marke | ၉ | ROBE | RT FRII | | | | 10h Mailir | a Addrass /S | Street | | | ES MAR | | h, or Town | State 7 | in Code) |
| nd 2 s alth an 27 is i | | MICHELLE | | | ER | | | , | | | | | | | | TLAND 21617 |
| permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. | | 20a. Method of Dis | position | 3 ☐ Removal fro | | | ace of Dispo | sition (Name matory or othe | of | -1 | | Date | | | | own, State |
| it. Pag rtment rtant: I | | 4 Donation | 5 Other (S | pecify) | on otate | CHE | CENT | ER | | - 1 | 2009 | | | | | , MARYLAND |
| permi Depa Impo any ii | | 21. Signature of Ft | meral Service | Licensee | | | FE 10 | LLOWS, | HE | LTEI K R(| NBEIN DAD | AND N | EWNA | M FUI | NERAI | HOME P. A |
| | | 23a. Part 1. Inter t | the disease, or | complications the | at caused | d the death | | | | | | | | | | Approximate Interval Between |
| Physician | | Immediate Cause disease or condition resulting in death) | (Final | a. pr | | MOV | ria. | | | | | | | | | Onset and Death |
| /Medical Examiner | | resulting in death) | | Due | to (or as | a consequ | uence of): | | | | | | | | | |
| p # | ner | Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or | nditions, nmediate erlying | b | to (or as | a consequ | uence of): | | | | | | | | | |
| e executed an and rial-transit | Examiner | Cause (Disease or that initiated events resulting in death) | S | c | to (or as | a consequ | ience of): | | | | | | | | | |
| 0 0 1 | _ | | | L _d | 10 (0. 0.0 | | | | | | | | | | | |
| The law requires that the death certificate be ate has been signed by the attending physici bage 2 should be detached for use as the bu | Physician/Medica | IF FEMALE: | | J | | | | | | | | | | | | |
| ath ce attendi for use | ian/ | 23b. Was deceden in the past 12 | | | ive birth | of pregna 2 Fetal at time of d | death 3 | ☐ Ectopic pre | | / | | | | | ite of deli | very Day Year |
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| ires that signed t | by PI | Part II. Other signi | | | | | ulting in the u | nderlying cau | se give | en in Par | t I. | | | | | the cause of death? |
| w requir been si should | eted | Mork | 1 | obes' | | | | | | | | | | | | obably 4 Unknown |
| The law cate has I | Completed | Mab | gomy | olysis | <u> </u> | 1 | _ | | | | | 24a. W au pe | itopsy erformed | 2 | prior to c death? | opsy findings available ompletion of cause of |
| | Be Co | 25. Was case refer | rred to medica | nal t | ai | lure | | | | 26. Pla | ce of Dea | 1 ∐ Ye th (Check on | | No | 1 □ Yes | 2 🗆 No |
| Physician: r this certific ral director, | မ | examiner? | | | | | | nt 3 DOA | | 4 🗆 1 | Nursing H | ome 5 R | | | | ify) |
| ding th. Th. After funer | Certification: | 27. Manner of Deat 1 Natural 2 Accident | tn 5 ☐ Pendir investi | g (A | ate of Inju #onth, Da | ay, Year) | 28b. Time o Injury | M 280 | lnjury Work 1 □ \ | yan (? Yes 2[| □No | 28d. Descril | oe now II | njury occur | rea | |
| er dea rector by the | tifica | 3 Suicide | 6 Could determ | not be 28e. Pl | | jury - At ho tc. <i>(Specif</i>) | | eet, factory, c | office | | | | n (Stree Town, S | | ber or Ru | ral Route Number, |
| oital o urs aft eral Dii | | | 170 | | | | | h accument of | h Alla a Alla | | 0.04 | | | | | otatad |
| To the Hospital or Attending Ph within 24 hours after deciding to the Funeral Director. After the completely filled in by the funeral | Medical | 29a. Certifier (Check only one) | 2 Medical | ng Physician: To Examiner: On the and n | tne best ne basis (nanner st | of examina | wiedge, deat tion and/or ir | n occurred at vestigation, in | n my o | ne, date pinion, d | eath occu | e, and due to irred at the tir | ne, date | e(s) and m and place, | and due | to the cause(s) |
| To the Vithin To the COMPI | Me | 29b. Signature and | title of certifie | 1 | | | | | | e numbe | | | | - | | , Day, Year) |
| 300 | | <u> </u> | Slyl | _ () | 4 | m | 2 | 1 | 259 | 35 | 10 | , | | 31 | 5/6 |) · |
| 7417 | | 30. Name and add | ress of person | who completed o | autse of o | death (Item | 1 23a) (Type, | Print) AM | | 200 | I M | edical | Mai | 21. | Ynı | |
| Sta | | 31. Date filed (Mor | ith, Day, Year | 2009 | Regist | rar's Signa | J. Soa | extend | Name of Street, or other Persons | | | | , va | ~1 | 101 | |
| Registr | | , | mnn • | 7 | | - /- | 1900 | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** FLOOK Alice Yvonne March 13, 22:35pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington 17404 Gardenwood Drive Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct. 9, 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 70 220-34-0233 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinatings he rollind at Maryland Washington Hagerstown 1 ☐ Yes 21 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17404 Gardenwood Drive 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) cafeteria manager 12 schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul E. Kunkleman Adelaide Hewett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Richard R. Flook - husband 17404 Gardenwood Drive, Hagerstown, Maryland 21740 permit, Pages 1 and Department of Health Important: If item 27 any Injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 18, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 East Wilson Blvd., Hagertown, Maryland 21740 Kalei Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** GIL10BLASTOMA MULTIFORME /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 🗷 No filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5.88 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD D45813 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-2 11110 MEDICAL CAMPUS RD SUITE 130 HAGERYOW MD 21742 SCOTT AWEGNER, MD 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State MAR 16 2009 Registrar

Robert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day M **Physician** obert FOGIE 100C Durchart 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 X M 2 □ F 74 218-30-9527 18, 1934 Maryland Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantment must be notified any ping. 1 ☐ Yes 2 No Director Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21773 USA 12552 Wolfsville Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖔 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Technician Auto Repair 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Stull. Roosevelt Burkhard Fogle မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12552 Wolfsville Road, Myersville, Maryland 21773 Doris J. Fogle/wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salem U. Methodist Mar.22,2009 Wolfsville, Maryland 5 Other (Specify) er Senic Licensee 21. Signature of Fig. 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 finter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) +14 POXIC Physician /Medical Due to (or as a consequence of): Examiner CEREBRAL SCHEM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical CORONARY 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy sate has been signed by the atte page 2 should be detached for it in the past 12 months? 1 □Yes 2 □No Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MOHAMMED D66892 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed Aziz, MD 251 East Antietam Street, Hagerstown, Maryland 21740

DHMH 17 Rev 1/2001

DK

State

Registrar

31. Date filed (Month, Day, Year)

MAR 25 2009

32 Registrar's Signature

Amended Item 29aper C.R.N.P. 03/10/2009 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 09443 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Jane B. Gingell March 8, 2009 4:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Walkersville Frederick Glade Valley Nursing Home 8. Date of Birth (Month, Day, Year) NOV 20, 1919 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 89 198-28-2007 Director Maryland Usual Residence of Decedent death with the Maryland 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Practical Examiner must be reathed an once. Emmitsburg Maryland Frederick 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 110 W. Main Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Bollinger Fannie Jackson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4029 Talder Road, Frederick, MD 21704-7745 Anna P. Davis, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Screenlary, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Crematory 3/09/2009 Winfield, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 210 W Main St, Emmitsburg, MD 21727 toy 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3 weeks /Medical Due to (or as a consequence of): Examiner ardiomy. y ears Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of The law requires that the death certificate be executed years burial-tran and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hranicrenaltai 1 Xes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1∐Yes 2. No 1 ☐Yes 2 ☐No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No Director: d in by the f 6 Could not be thin 24 hours after des the Funeral Directo 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Telegraphysisian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

X Certified Registered Nurse Practioner 29a. Certifier Medical (Check only one) within 2

To the F

complete 29b. Signature and title of certifier 29c. License number WJZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathryw D. I roupe CRW 1475 Toward. 1475 Tanof 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of | Marylar | | artment of I rtificate of | | nd Mental Hy | /giene Reg. No | 2000 | 09444 |
|---------------------|--|-------------------|--|---|---------------------------------|-----------------------|--|--------------------------------|--|--------------------|------------------------------------|--|
| | Dhyaiai | a a | 1. Decedent's Name (First, Middle | e, Last) | | | | | 2. Date of D Month | eath Da | y Year | 3. Time of Death |
| | Physici /Medio | | Janet Sherry G | | | | 1 | | March | 8, 20 | 009 | 5:45 p ^M |
| | Examir | ner | 4a. Facility Name (If not institution Shady Grove Adv | | | | 4b. City, Town, o | | Death | | . County of Death | |
| | Funeral | | 5. Social Security Number | | Spitai 7. Age (In yrs. | last birthday) | Rockvi] | If Under 24 | | | ontgomery 9. Birthp | place (State or Foreign |
| | Director | | 220-46-1882 | 1 □ M 2 🛣 F | 59 | Yrs. | Months Days | Hours | | nay, year) 17/1 | | nington, DC |
| سفا | pu . | | Usual Residence of Decedent 10a. State 10b. County | | 10c Cir | ty. Town or Lo | eation | | | | | 0d. Inside City Limits |
| | Maryland | ō | | | | | , cation | | | | | 1X Yes 2 □ No |
| 17 | the N | rect | Maryland Montgo | omery | Roci | kville | 10f. Zip Code | | | 10g. Ci | tizen of What Cour | ntry? |
| | h with | al D | 545 Elmcroft B | lvd Apt.#10 | 0105 | | 20850 | | | USA | | |
| | hours after death with the tural", or items 23a or 28a at Examiner must be noti | Funeral Director | 11. Marital Status | 12. Was Deced | dent Ever in U | .S. 13. | Was Decedent of I | Hispanic Origi an, Mexican, | n? (Specify Yes or N Puerto Rican, etc.) | 0- | 14. Race - Americ Black, White, | |
| 36 | s after | by Fu | 1 X Never Married 2 Mar | ried 1 □Yes 2 If Yes, Give | 2 🔀 No e | | 1 □Yes 2 🛣 No | | , | } | | hite |
| 9 | hour fural | ed b | 3 Widowed 4 Divorced | Year or Da | tes: | 16a. Dece | dent's Usual Occu | pation | | 16b. K | (ind of Business/Ind | dustry |
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| nd | be file | Be | 17. Father's Name (First, Middle, Morris A. Grube | * | | | | | s Name (First, Middle | e, Maider | n Surname) | |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | 은 | | | | 105 15-11 | 6 dd (Cin | | . Brown | han City | as Taura Ctata Tin | · Cordo) |
| Maj | d2shthantthantrantrantrant | | 19a. Informant's Name/Rélations Ruth F. Herson | | | | | | or Rural Route Num. ockville, | | | 850 |
| ē, | t Health tHealth tem 27 other tr | 1 3 | 20a. Method of Disposition | , SIBCCI | 20b. F | | osition (Name of matory or other pla | | Date | | ocation - City or To | |
| e E | Pages ient of nt; If it ry or o | | 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | | | | | /12/2009 | Ade | lphi, Mar | yland |
| Baltimore, | permit. Pages Department of Important; If it any injury or once. | | 21. Igyana of Exceral Service | | | F.1 | 2. Name and Addr | ess of Facility | ERAL DIREC | ' ''''' ፐብነ | J TNC | |
| <u> </u> | 9 9 E E 9 | (S) 1 | | | | | | | Pike, Rocl | | | |
| | | | 23a. Part 1. Enter the disease, or shock, or heart failure. List | complications that ca only one cause on ea | used the deat ch line. | h. Do not en | ter the mode of dy | ing, such as c | ardiac or respiratory | arrest, | | Approximate Interval Between Onset and Death |
| nen, | Physician | iii ii | Immediate Cause (Final disease or condition resulting in death) | | | | | | | | | |
| 4 | /Medical Examiner | | recording in deathy | | or as a conseq | | | | | | | |
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| B | executed n and ial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | _c Sepsis | 5 | | | | | | | |
| , O | be exe ician ar burial-t | Ä | resulting in death) Last | Due to (c | or as a conseq | uence of): | | | | | | |
| 8760, | ate nys he | Physician/Medical | | d | | | | - | | | | |
| 9 X | certifi ding se as | /Me | IF FEMALE: | 23c. If yes, outc | ome of prean | ancv | | | | | 22d Date of delive | |
| Box | ath itter | clan | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No | 1 ☐ Live bi | irth 2 ☐ Feta ant at time of | al death 3 [| ☐ Ectopic pregnan☐ Other (specify) _ | су | | ľ | 23d. Date of delive Month | Day Year |
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| | ires that the de signed by the a be detached for | by P | Part II. Other significant conditi | ons contributing to dea | ath but not res | ulting in the u | nderlying cause gi | ven in Part I. | | | | ne cause of death? |
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| ec | aw Is b | Completed | | | | | | | 24a. Wa | psy | 24b. Were auto prior to co | psy findings available mpletion of cause of |
| a F | iclan; The lav certificate has rector, page 2: | | | | | | | | pen 1 □ Yes | formed? 2¥€ No | death? | 2 □No |
| Vit | Physiclan; r this certific ral director, | æ | 25. Was case referred to medica examiner? | Haspital | | | Ot | | of Death (Check only | | . – | |
| o | Physer this eral di | Certification: To | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 28a. Date o | npatient 2 f Injury | 28b. Time o | III 3 LI DOA | 4 🗀 Nurs | sing Home 5 Res | | | ý) |
| ion | nding ath. r; After e funer | aţiol | 1X Natural 5 ☐ Pendir 2 ☐ Accident investi | | n, Day, Year) | Injury | | rk?]Yes 2 □ No | 0 | | | |
| Division | r Atte er deg recto | tific | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern | ained 28e. Place | of Injury - At h | ome, farm, sti fy) | reet, factory, office | | | (Street a | nd Number or Rura e) | al Route Number, |
| | ital or urs afte ral Dir lled in | | | | | | | | The state of the s | | | |
| | To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page? | edical | | ng Physician: To the l Examiner: On the ba and mann | sis of examina | | | | | | | |
| | To the within 2 To the Comple | Mec | 29b. Signature and title of certifie | | er stated. | | 29c. Licen | se number | | 29d. Da | ate signed (Month, | Day, Year) |
| | 10 | | > My 9 | h | | | D672 | 38 | | Mar | ch 9, 20 | 09 |
| | , , | | 30. Name and address of person | | , | , , , , , | · · | | | | | |
| | | | Dr. Payam Chini | | | | Drive, R | ockvil | le, Maryla | and | 20850 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) MAR 11 | 2009 | egistrar's Signa | ba | Kil | | | | | |

DHMH 17 Rev 1/2001

| | | | For State | | State o | f Maryla | | partmer <i>ertificat</i> | | | | Mental H | | 00 | 200 | ngl. l. |
|---------------------|--|-------------------|---|-------------------------|------------------------------------|-----------------------------|-----------------|---------------------------------|------------------|------------|-------------|--------------------------|-----------------|-------------|------------------------|--------------------------------------|
| | | | Registrar 1. Decedent's Name (First, | Middle L | ast) | | | | 01 1 | Dean | 1 | 2. Date of D | Reg. No | ٥. ٢. ر | 100 | 3. Time of Death |
| | Physicia | an | _ | | | C | imsley | | | | | Month | 5 . | | Year 009 | 11:20 A |
| 146 | /Medic | | 4a. Facility Name (If not ins. | nie titution, ai | Hugh | | Imsrey | | Town, o | r Location | n of Death | March | | | of Death | 11.20 A. |
| J. P. | Examin | er | Shady Grove | | | | 1 | | | | | | | Mon | tgome | rv |
| | Funeral | | 5. Social Security Number | 6. | Sex | | rs. last birthd | ay) If Unde | ckvi r 1 Year | If Unde | er 24 Hrs. | 8. Date of B | irth | 1101 | 9. Birthp | place (State or Foreigntry) |
| п | Director | | 237-62-8219 | | 1 🛣 M 2 🗆 F | | 68 Yrs | Months | Days | Hours | Min. | Jan. 1 | 5, 1 | 941 | North | n Carolina |
| | P. | | Usual Residence of Decede | | | 1.0 | | | - | | | | - 10 | | 14 | Od Incide City I in it |
| | arylar show | _ | 10a. State 10b. C | ounty | | 100. | City, Town or | Location | | | | | | | ' | 0d. Inside City Limit 1 ☑ Yes 2 ☐ No |
| | Ba-f | Director | | ntgor | nery | | Gaitl | nersbu | | | | | 10- 0 | itinan of l | What Coun | |
| | a or 2 | | 10e. Street and Number | | | | | | p Code | | | | 10g. C | | | |
| | sath v | eral | 218 Sportsma | ın Wa | 12. Was Dece | adent Ever in | 118 1 | | 0878 | | rigin? (Sn | ecify Yes or N | lo- | | ed St | |
| | ter de | Funeral | 11. Marital Status1 ☐ Never Married 2 ☐ | l Married | Armed Fo | orces? | | If Yes, spe | cify Cuba | an, Mexica | an, Puerto | Rican, etc.) | | | ck, White, | |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be profiled at | þ | 3 ₩ Widowed 4 Div | | If Yes, Gi Year or D | ve | 963 | 1 □ Yes | 2 X No | Specify | y: | | | Specify | Whi | te |
| Õ | 2 hot | Completed | 15. De | cedent's E | Education | | 16a. De | ecedent's Usu | | | ant of work | ina | 16b. l | Kind of B | usiness/Ind | |
| 21 | thin 7 e. an "n | ld l | Elementary/Secondary (0 | | rade completed) College (1 | 1-4or 5+) | (iii | e. DO NOT u | ise retired | d) | JSL OF WORK | irig | | | | |
| 21 | ed wil | ပ္ပ | | | 5+ | - | | Attori | ney | | | | | | | ernment |
| nd | e d al e | Be | 17. Father's Name (First, M | iddle, Las | st) | | | | | 18. Moth | her's Name | e (First, Middl | e, Maide | n Suman | ne) | |
| Х | 2 should to and Meni Is marked raumatic | မ | | | | Grims1 | | | | | | Flora | | | | |
| Jar | 2 sh h and rs rr | | 19a. Informant's Name/Rel | | _ | | | | | | | al Route Num | | | | , |
| e, | and Healt | | John David Gr 20a. Method of Disposition | imsl | ey/Son | 201 | | | | | | thersb | | | yland City or To | |
| وّ | tiges int of l | | 1 ☑ Burial 2 ☐ Crema | | | State | cemetery, | sposition (Na crematory or o | other plac | ce) | | | | | , | |
| Baltimore, | permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any Injury or other traumatic onge. | | 4 ☐ Donation 5 ☐ Ott | | | Re | edmond | Cemete | | ee of Faci | | /2009 | | | | <u>ah</u> |
| Ba | permit. Pages 1 Department of I Important: If ite any Injury or of | | Signature of Furieral Se | TVICE LICE | D'A R | 2 Osl | - | | | | | Vol Fu | | | | D. 20877 |
| | | | 23a. Part 1. Enter the disea | se, or cor | mplications that of | aused the d | | | | | | | | LSDU. | Lg, m | Approximate |
| | Physician | | shock, or heart failure Immediate Cause (Final | . List only | y one cause on e | each line. | | | | | | | | | | Interval Between Onset and Death |
| | /Medical | | disease or condition resulting in death) | 4 | a. Sepsi | | sequence of): | | | | | | | | _ | |
| | Examiner | | | - 1 | Pneum | | , | | | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate | J | D | | sequence of): | | | | | | | | | |
| 9 | cuted nd ransit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 1 | c | | | | | | | | | | | |
| Ö, | e exe | E | resulting in death) Last | | Due to | (or as a cons | sequence of): | | | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | dical | | • | d | | | | | | | | | | | |
| 9 | ertific ling p | Mec | IF FEMALE: | | 20 11 | | | | | | | | T | | | |
| Box | eath certific attending p for use as | ian/ | 23b. Was decedent pregna in the past 12 months | | | birth 2 🗆 F | etal death | 3 Ectopic | | су | | | | | te of delive onth | ery Day Year |
| Ö | at the de by the stached | Physician/Me | 1 □Yes 2 □ No 9 □ Unknown | | 9 Unkr | nant at time nown | oi dealii | 5 ☐ Other (s | pecity) _ | | | | | | | |
| σ. | ge g | | Part II. Other significant co | onditions | contributing to d | eath but not | resulting in th | e underlying | cause giv | en in Part | t i. | 23e. Dio | I tobacco | use conf | tribute to th | ne cause of death? |
| Records, | uires 1 sign 1d be | d by | | | | | | | | | | 1 🗆 | Yes 2 | 2 X No | 3 ☐ Prob | oably 4 ☐ Unknow |
| 20 | w requir s been s should | Completed | | | | | | | | | | 24a. Wa | san | 24b. | Were auto | psy findings availabl |
| Re | The law cate has page 2 t | g E | | | | | | | | | | aut per | opsy formed? | | prior to con death? | mpletion of cause of |
| Vital | iclan: Th certificate rector, pag | | 25. Was case referred to m | edical | Ĭ | | | | | 26 Pla | ce of Deat | 1 ☐ Yes h (Check only | | 0 | 1 ☐ Yes | 2 ∐No |
| > | nysiclan: nis certific director, | o Be | examiner? 1 ☐ Yes 2 🔀 No | | Hospital: | Inpatient 2 | 2 ☐ ER/Outpa | atient 3 □ D | OA Oth | or: | | ome 5 Re | | 6 □Oth | ner (Specif | |
| 1 of | g Ph ter th | Certification: To | 27. Manner of Death | | 28a. Date | of Injury oth, Day, Year | 28b. Tim | | 28c. Inju | ry at | | 28d. Describe | | | | 3/ |
| <u>.ö</u> | uttending I death. ctor: After y the funer | atio | 2 Accident | Pending nvestigation | on | iiri, Day, Toai | ,, | м | | Yes 2 | □No | | | | | |
| Division | r Atte | titic | | Could not determine | d 28e. Place | of Injury - A | | street, factor | y, office | | | | (Street a | | ber or Rura | al Route Number, |
| | Ital o Irs aft ral Di | | | | | | | | | | | | | | | |
| | Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune | ical | (Check only 2 Me | | Physician: To the aminer: On the b | pasis of exan | | | | | | | | | | |
| | To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu | Medical | one) 29b. Signature and title of o | ertifier | and man | iner stated. | | 20 | c. Licens | se number | r | | 29d D | ate sinne | ed (Month | Day, Year) |
| | | | D \ | Cimiel | 100000 | \ L | | 23 | | | • | | | | | |
| • | 15+1 | | 20 Name and address | - P | James and a completed course | | | no Print' | D 6 | 2995 | | | _Mar | ch 6 | , 200 |)9 |
| _ | | | 30. Name and address of p Petek Donmez, | | · | , | , , , | | איז ב | Roc | kvill | e. Mar | vlan | d 20 | 850 | |
| | Sta | | 31. Date filed (Month; Day, | | | | | | 1 V C 9 | TOC | | , mai | Jian | 20 | 550 | |
| | Registr | | MAR 1 | 1 20 | 09 | was . | gnature , 49 | all. | | | | | | | | |
| | | | | | / | / | | | | | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 7, 2009 **Physician** 7:36 p M Robert M. Greenberg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Chevy Chase Home Brighton Gardens Nursing If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year 10/24/1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F Yrs Washington, DC 92 Director 218-38-7332 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show event, the Medical Examiner must be nutified at 1X Yes 2 □ No Director Odenton Anne Arundel Maryland 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code ō 21113 USA or items 23a 2814 Settlers View Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 721 College (1-4or 5+) 5+ Elementary/Secondary (0-12) Medical Psychiatry 7 is marked other traumatic event, # permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Greene Rae Levin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2814 Settlers View Drive, Odenton, Maryland 19a. Informant's Name/Relationship (Type. Print) 21113 Harold E. Greenberg-Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematorium 03/11/2009 4 ☐ Denation 5 ☐ Other (Specify) Falls Church, Virginia 21. Signature of Fundal Service Licensee 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. MO1255

Edward Sagel Funeral Direction 1091 Rockville Pike, Rockvil

23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years Parkinsons Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): be executed Examir burial-tran Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed by the a Ö 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has page 2 s autopsy certificate 2 🕱 No 1 ☐ Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∑XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral To the Hospital or Attending PP within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and titl March 9, 2009 DO7147 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completes 5530 Wisconsin Avenue, Suite 700, Chevy Chase, MD 20815 Allen A. Nimetz, MD, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 11 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \nearrow \bigcirc \bigcirc Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2009 0723 Daniel L. Green March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NICOMICO PENINSUUM REGIONAL SAHS6414 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 🖾 M 2 🗆 F 65 Yrs. 254-66-1247 **Director** March 9, 1944 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f shorevent, the Medical Exercitors must be notified at 1 ☐ Yes 217 No Director Delmar MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21875 U.S.A. 205 Highland Avenue death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.

7 is marked other than traumatic event, Elementary/Secondary (0-12) College (1-4or 5+) Poultry 8 Maintenance Mechanic permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if Item 27 is marked othany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Garfield Green Willie Veta Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Delmar, MD Betty J. Green (wife) 205 Highland Avenue 21875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 16, 2009 Bluffton, Georgia 4 ☐ Donation 5 ☐ Other (Specify) St. Lukes Cemetery 22. Name and Address of Facility
Short Funeral Home
13 East Grove Street 21. Signature of Funeral Service Licensee Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAMO, ony of Arry DUMS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the distribution of Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the death certificate be executed and Due to (or as a consequence of) physician a sthe burial-t attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires AORTICSRNO1.S 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? KIDNEY 24a. Was an has e 2 s autopsy performe certificate 1 ☐Yes 2 ☐No Convany 1 ☐ Yes 2 KNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this (₽ Certification: To After th funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation (Month, Day, Year) Injury 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

-MP

altimore, Maryland 21215-0036

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Box

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Division of Vital Records,

Registrar

State

29a. Certifier

Kene

31. Date filed (Month,

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100E Carroll

Desmarais

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Salisbury, md. 2180

29d. Date signed (Month, Day, Year)

3-09-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** Philip Gordy a^{M} March 8, 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 1514 Riverside Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1**X** M 2 □ F 218-34-9064 71 Director 11/24/1937 Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Exp., in an unsit to institled at Director 1 X Yes 2 □ No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2¶ No Specify ş Specify. white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
accountant Elementary/Secondary (0-12) College (1-4or 5+) accounting permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, Insulose. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul C. Gordy Anne Grier ပ္ 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 6043 Hounds Bay Circle, Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Debra Littleton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/12/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²Hon and Address of Facility al Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician onal disease or condition resulting in death) /Medical (or as a consequence f): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate performed' 1 □Yes 2 100 1 ☐ Yes 2 🗆 No the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records.

Division of Vital

Registrar

31. Date filed (Month, Day,

DIMAGA R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

e hus

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month Peter David Hess 8, 6:39 p. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick 232 Lake Coventry Drive Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Dec. 27, 1939 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 ☑ M 2 □ F 69 212-38-7788 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick Frederick Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 USA 232 Lake Coventry Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Whisner Robert E. Hess 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21702 232 Lake Coventry Drive, Frederick, Maryland Rita Hess - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-14-2009 Resthaven Memorial Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between

Physician /Medical Examiner

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neral Director: Af

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29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

-10 32. Registrar's Signature

Department of H Important: If ite any Injury or ot once.

Physician

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shor Exeminer must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

icate has been si page 2 should b

To the Hospital or Attending Physlcian: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Examiner Medical Certification: To

| Immediate Cause (Final disease or condition | METASTATIC PANCREATTE | CANCER | 4 YEARS |
|---|--|--|---|
| resulting in death) | Due to (or as a consequence of): | | |
| Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause, (Disease or injury | Dus to (or as a consequence of): | | |
| that initiated events resulting in death) Last | Due to (or as a consequence of): | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregnancy 1 | | Date of delivery Month Day Year |
| Part II. Other significant conditions cor | tributing to death but not resulting in the underlying cause given in | Part I. 23e. Did tobacco use co | ontribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown |
| | | 24a. Was an autopsy performed? | b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No |
| 25. Was case referred to medical examiner? | | Place of Death (Check only one) | NIH |
| 1 Yes 2 Yes No | ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 | □ Nursing Home 5 Residence 6 □ 0 | Other (Specify) |
| 27. Manner of Death 1 ★ Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? M 28c. Injury at Work? 1 □ Yes | 28d. Describe how injury occ 2 ☐ No | urred |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Num City or Town, State) | mber or Rural Route Number, |
| 29a. Certifier Check only Check only Control Medical Examination | sician: To the best of my knowledge, death occurred at the time, oner: On the basis of examination and/or investigation, in my opinion | date and place, and due to the cause(s) and on, death occurred at the time, date and place | manner as stated. e, and due to the cause(s) |

29c. License number

A 31761

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 10, 2009 Year **Physician** FRANCES HISER 9:48 AM MUSSER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Feb. 6, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🖔 F Months Days Hours Min. ^Y1918 577-16-8635 Maryland 91 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show Director 1X Yes 2 □ No MD Gaithersburg Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? death with 20877 415 Russell Ave. #104 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 traumatic event, the "Mudical Express ٩, 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 2 White Specify: 3 X Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Typewriting Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Musser Mary Gartner ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Germantown, MD 20876 Elizabeth Crider (Daughter) 12119 Red Admiral Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 2/2 Urosep 194 disease or condition resulting in death) /Medical Due to (or as a con equence of): Examiner Dement Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ cate has been sig page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform The certificate 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check onl one) examiner' Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pont 24 hours after death.

Funeral Director: After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1' Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in I 29a, Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 90

Registrar

MC

31. Date filed (Month, Day, Year)

MAR 11

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Registrar's Signature

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| | Please Type or Print State of Mary 1- Registrar | /land / Depa | delible Ink. Ensure Al artment of Health and N rtificate of Death | | ne O | 0945 |
|---|--|------------------------------------|--|--|---|--|
| ysician Medical | 1. Decedent's Name (First, Middle, Last) Abe Hirshorn | | | 2. Date of Death Month | Day Year 7, 2009 | 3. Time of Death 2:15 A. M |
| aminer | 4a. Facility Name (If not institution, give street and number) Montgomery Village Health Ca | | 4b. City, Town, or Location of Death Gaithersburg | | 4c. County of Death Montgomer | y |
| eral ctor | 5. Social Security Number 072-18-3149 Usual Residence of Decedent | n yrs. last birthday) 85 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Yes | ar) Cour | place (State or Foreigr ntry) York |
| fflad at | 10a. State 10b. County 10 | oc. City, Town or Loc Gaithersb | | | 1 | 0d. Inside City Limits 1 X Yes 2 □ No |
| incroust be notified Funeral Director | 10e. Street and Number 18908 Montgomery Village Ave | nue | 10f. Zip Code 20886 | 10g. | Citizen of What Cour | itry? |
| | 11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced 12. Was Decedent Ever | lavy 1 | Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto ☐Yes 2 XNo Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Americ Black, White, of Specify: Whi | etc. |
| t, the Medical Exam | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) | (Give life. L | lent's Usual Occupation kind of work done during most of workl DO NOT use retired) nter | ing | ept. of De | • |
| traumatic event, the Me. To Be Comple | 17. Father's Name (First, Middle, Last) Joseph Hirshorn | | | e (First, Middle, Maid e Roth | den Surname) | |
| ther traum | 19a. Informant's Name/Relationship (Type. Print) Deborah R. Hirshorn - Wife | | g Address (Street and Number or Rura 8 Montgomery Villa | | <u>Marylan</u> | d 20886 |
| any injury or other once. | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | National | crematory 3/9/2 Name and Address of Facility anzansky—Goldberg 170 Rockville Pik | 2009 Fal | | , Virginia |
| ian ical | 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final | eath. Do not ente | | | iie, maryi | Approximate Interval Between Onset and Death |
| Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | onsequence of): | | | | |
| | that initiated events resulting in death) Last C. Due to (or as a co | nsequence of): | | | | |
| letached for use as the bu Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown | Fetal death 3 | Ectopic pregnancy Other (specify) | | 23d. Date of delive Month | ery Day Year |
| p pe | Part II. Other significant conditions contributing to death but no | ot resulting in the un | derlying cause given in Part I. | | o use contribute to th | |
| page 2 | | | | 24a. Was an autopsy performed 1 ☐ Yes 2 👿 | prior to cor death? | psy findings available npletion of cause of |
| director, | | 2 ☐ ER/Outpatient | 26. Place of Death | (Check only one) | 6 □Other (Specify | |
| ation: | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Ye) 28b. Place of Injury building, etc. (S | At home, farm, stre | 28c. Injury at Work? M 1 □ Yes 2 □ No | 28d. Describe how in | njury occurred and Number or Rura | |
| ompletely filled in by the Medical Certific | 29a. Certifier (Check only one) 29a. Certifying Physician: To the best of model Examiner: On | aminati a n and/or inv | occurred at the time, date and place, restigation, in my opinion, death occurr | and due to the cause ed at the time, date a | e(s) and manner as s and place, and due to | tated. the cause(s) |
| g g | 29b. Signature and title of certifier | -11 | 29c. License number | 004 1 | Date signed (Month I | D 1/4-0-1 |

Division of Vital Records, P.O. Box 68760, 😽 To the Hospital or Atte within 24 hours after des To the Funeral Directol completely filled in by th

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

March 7, 2009 H005128

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Anushiravan Dadgar D.O. 10110 Molecular Drive, Siyte 206, Rockville, Md. 20850

State Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 16 2009

Registrar's Signature

Williamsport, Maryland 21795

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 09453 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 **Physician** 2009 John Jones 3:03p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/27/1924 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 X M 2 □ F 108-26-4523 84 **Director** Tennesse Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show my or other tranmatic event, it. "Medical Examinar mist be natified at my or other tranmatic event, it. "Medical Examinar mist be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9737 Mt. Pisgah Rd., #512 20903 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 AYes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: American \$ Year or Dates: 1943-46 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) College Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P.S. Jones Pattie Taylor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Jones, Jr./Son 9737 Mt. Pisgah Rd., #512, Silver Spring, MD 20903 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Pages Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rolling Green Mem.Pk. 3/9/2009 West Chester, Penn. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee ndro die 7400 Georgia Avenue, NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Severe Hemorrhagic CVA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions Examiner flant leading to in medicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day P.0. 5 Other (specify) s been signed by the s 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Dementia 1 Tes 2 No 3 Probably 4 Unknown Hypertension certificate has b irector, page 2 st 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 □Yes 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D67589 2/25/2009 30. Name and address deperson who completed cause of death (Item 23a) (Type, Print) 4500 Forest Glen Rd., Silver Spring, MD Dr. Harold V. Lawson. 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 11 2009 Registrar

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

sa or 28a-f shot the second se

or items 23a Examiner must

"natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic event the Manay injury or other traumatic

Medical

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

bunal-tran physician the SE nse s atter for signed by the a been page 2 this certificate director, funeral After

Examine Physician/Medical ð Be Certification: death. ours after death.

neral Director: A
filled in by the fu within 24 hours a

Completed

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

death certificate be executed P.O. Box 68760. Division or Vital Records. or Attending To the Hospital of within 24 hours af

3H-1

State Registrar

29c. License number 0060796

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21740 Dr. Farid Murshed, 1126 Opal Court, Hagerstown, Maryland

31. Date filed (Month, Day, Year) 6 2009

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 20,2009 2009 **Physician** DOROTHY ALDORA JENKINS 5:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS LA PLATA CENTER CHARLES LA PLATA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-26-1927 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Davs MISS. Hours 1 □ M 2√2 F 427-48-6619 81 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f shov event, the Medical Examiner must be notified at MD. CHARLES LA PLATA 1X Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number e filed within 72 hours after death with tal Hygiene. other than "natural", or items 23a or : 20646 U.S.A. 1 MAGNOLIA DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XHo Specify 2 Specify: WHITE ¥☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LAYOUT WORKER PRINTING CO. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental DEWEY DEWIT HINTON ELOISE HELTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trai MICHAEL JENKINS, SR.-SON 3879 PINE CONE CR. WALDORF, MD. 20602 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 3-20-09 ALEX., VA. M00479 22. Name and Address of Facility 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 na Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) PINCINCO **Physician** /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 es 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes or Attending Physician: 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State

29b. Signature and title of certifier

30. Name and address of person v

31. Date filed (Month,

VZ

Registrar

DHMH 17 Rev 1/2001

DIL

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

123

29d. Date signed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Dav Year MEO KHOUSAKOUN MARCH 2009 10:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death GREATER LAUREL HEALTH & REHAB. LAUREL PRINCE GEORGES LAUKEL

1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 🕱 F **Director** 214-04-0538 85 1923 LAÓS MAY 18, Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City. Town or Location ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 Yes 2 □ No MD. PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8300 RAMBLER DR. 20783 LAOS 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Tes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No 2 Specify: Specify: 3 Widowed 4 Divorced Year or Dates: ASIAN Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental and Mental ၉ KOU KHIENG KHAM KHIENG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. WEIYEE HUYNH/NEPHEW 8300 RAMBLER DR., HYATTSVILLE, MD.20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 3-14-2009 BRENTWOOD, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 1 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ <u>SENILE</u> DEMENTIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐ Yes 2**X**□No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 😾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural neral Director: , filled in by the f 2 Accident 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Procertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D24721 MARCH 6, 2009

State Registrar LAUREL BOWIE RD., SUITE 208, LAUREL, MD. 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

14333

Registrar's Signature

SADIQ,

SYED A.

31. Date filed (Month, Day, Year)

MAR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0240 AM KIMBERLY ANN KNOPP March 200 06 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Hospital Talbo Easton Memorial If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9. Birthplac Social Security Number 7. Age (In vrs. last birthday) (State or Foreign Year) 1962 Days Hours 1 □ M 2 🕱 F MARYLAND 214-90-8903 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No TALBOT ROYAL OAK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24921 DEEP NECK ROAD 21662 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No WHITE Specify Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN KNOPP AUDREY SEWELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUDREY KNOPP/ MOTHER 1020 N. WASHINGTON ST., APT.603, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3-7-2009 CHESAPEAKE CREMATION: STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Joseph 200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neuman19 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lorus a re Due(fo (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ÛNo 9 ☐ Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🕎 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 🗷 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760,

P.0.

Physician

/Medical

Examiner Physician/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be မှ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Expressible notified at once.

Baltimore, Maryland 21215-0036

ģ Completed r this certificate h

Be

Certification: To

Medical

State

Division of Vital Records, To the Hospital or Attending Pl within 24 hours after death. • To the Funeral Director: After it completely filled in by the funeral

| 29a. Certifier (Check only one) 2 Certifying Physi 2 Medical Examine | ician: To the best of my knowledge, death occ er: On the basis of examination and/or investig and manner stated. | urred at the time, date and place, a pation, in my opinion, death occurre | nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s) |
|--|--|--|---|
| 29b. Signature and title of certifier | | 29c. License number | 29d. Date signed (Month, Day, Year) |
| Ideal Carl | w? | D0059761 | 3/6/2009 |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DØ\$59761 1 MD 2160 1 2195. Washington St.

29d. Date signed (Month, Day, Year) 3/6/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horider Sorrohmo

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician William King C. March 10,2009 10:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 7220 Roanne Drive Oxon Hill Prince George's 8. Date of Birth (Month, Day, May 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours ^{Year)} 1931 Director 578 42 1974 77 Washington DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10h County 10c. City Town or Location if than "natural", or items 23a or 28a-f show 10d. Inside City Limits Directo 1 ☐ Yes 2√ No Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7220 Roanne Drive 20745 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: þ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Letter Carrier US Postal Service permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elton Leonard King Margaret Eloise Clemmer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda King (Daughter) 100 Pates Drive, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Lee Crematory March 12, 2009 Clinton, Maryland 21. Signatur o Funeral Se 22. Name and Address of FacilityLee Funeral Home, inc 6633 01d 04 Alexandria Ferry Road, Clinton, Md disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. 23a. Part 1. Epter the shock, if hear Approximate Interval Between Onset and Death Immediate ause inal disease o condition resulting in death MUINO MO **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to introduct cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation of Funeral Director: / 2 ☐ Accident 1 🗆 Yes 2 🗆 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of p erson who completed cause of death (Item 23a) (Type, Print) Frank M. -Ryan, M.D11701 Livingston Road#103, Fort Washington, MD 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 122009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 09460 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19,2009 **Physician** MARCH JOHN LOUIS KAGEL 12:05P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4210 SOUTHWINDS PLACE WHITE PLAINS CHARLES 6. Sex If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 √ M 2 ☐ F Months Days Hours ILL. 67 349-34-7150 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evantimational to writh deat any Injury or other traumatic event, Ite Medical Evantimation at the Medical Evantimation of the province of the pr MD. CHARLES WHITE PLAINS 1 ☐ Yes 21 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4210 SOUTHWINDS PLACE 20695 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Xo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RECYCLING CO. 12 GENERAL MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS HENRY KAGEL CHRYSTALIN GRETTA RICHARDSON ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENE M. KAGEL-SPOUSE SOUTHWINDS PL. WHITE PLAINS, MD. 20695 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 3-20-09 ALEX. VA. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE
LA PLATA, MARYLAND 20646 M00479 Uli 23a. Part 1. Enter the disease, or complication, that caused the death, shock, or heart failure. List only one ease on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death e on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: d in by the f 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Ba State Registrar DHMH 17 Rev 1/2001

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| | | • | For State Registrar | State of N | viaiyiaiic | | rtificate of I | | vierilai my | Reg. No. | 2000 | 09461 |
|------------|---|---------------------|--|--|------------------------------------|----------------------|--|--------------------------------|-----------------------------------|--------------------------|---|--|
| F | Physici | an | 1. Decedent's Name (First, Middle | | | | | | 2. Date of D Month | Day | | 3. Time of Death 1:31 am |
| age of | /Medic | al | 4a. Facility Name (If not institutio | Hung Cha | | | 4b. City. Town, or | Location of Death | March | 05 4c. | 2009 County of Death | |
| | Examin | er | | oss Hospital | , | | | Silver Spr | | | Montgo | |
| e 6 ; | Funeral Director | | 5. Social Security Number 144-24-5860 | | Age (In yrs. la | st birthday) Yrs. | | If Under 24 Hrs. Hours Min. | | ay, Year) | 9. Birth | place (State or Foreign intry) China |
| 4 | ** | | Usual Residence of Decedent | | | | | | August | 0, 17. | 17 | |
| | arylan show | 7 | 10a. State 10b. County | | 10c. City, | Town or Lo | | 1 Ci | _ | | | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No |
| | the M 28a-f notifie | recto | Maryland Mon | ntgomery | | | 10f. Zip Code | lver Sprin | g | 10g. Cit | izen of What Cou | |
| | h with | al Di | | ndler Court | | | | 20903 | | | U.S. | Α. |
| 336 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced | If Yes, Give | s? 【]No | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2⊠ No | | pecify Yes or N o Rican, etc.) | 0- | 14. Race - Amer Black, White Specify: | |
| 2-0 | 72 hou natura Jical E | eted | 15. Deceder | nt's Education est grade completed) | | (Give | dent's Usual Occup | during most of wor | king | 16b. K | ind of Business/li | ndustry |
| 21215-0036 | vithin "ne. | Completed | Elementary/Secondary (0-12) | College (1-4d | or 5+) | life. | DO NOT use retired Profe | i) | 9 | Ϊ, | Flootrice1 | Engineer |
| N | 2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Me | | 17. Father's Name (First, Middle | 1 | | | rrore | 18. Mother's Nar | ne (First, Middle | | Electrical Surname) | EligTileer |
| lan | fental fental rked c | To Be | Dao Ya | ng Lin | | | | | Ying | Mei Cl | hen | |
| Maryland | 2 should and his mais main auma | | 19a. Informant's Name/Relation | ship (Type. Print) | | 19b. Maili | ng Address (Street | and Number or Ro | ıral Route Numi | ber, City o | or Town, State, Z | ip Code) |
| ,e | 1 and 2 Health em 27 i | 1 | Anchen Lin - St | pouse | 20b. Pla | ace of Dispo | hindler Cou | 1 | Spring, | | and 20903 ocation - City or 1 | Town State |
| mor | Pages lent of nt: If it ry or o | ı | 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (| | te ce | metery, cre | matory or other plac oln Cremato | | 11/2009 | | ntwood, Ma | |
| Baltimore, | permit. Pages 1 and Department of Health important: If item 27 any Injury or other tr | | 21. Signature of Funeral Service | | 1 | 22 H | 2. Name and Addre ines-Rinald | ss of Facility i Funeral | Home, Inc | | | |
| · | Physician /Medical Examiner | | 23a. Part1. Enter the disease, on hook, or liear failure. Lis Immediate Lause (Final disease or condition resulting in death) | a. Ather Due to (or a | rosclero as a consequ Cancer | Do not en | | ng, such as cardia | | | pring, Mar | Approximate Interval Between Onset and Death |
| 68760, 04 | tificate be executed g physician and as the burial-transit | ledical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | as a consequ | | | | | | | |
| .O. Box | ath cer attendin for use | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | n 2 ☐ Fetal t at time of de | death 3[| □Ectopic pregnance □ Other (specify) _ | / | | | 23d. Date of deli | very Day Year |
| ds, P. | w requires that the d been signed by the should be detached | | Part II. Other significant condit | ti ons contributing to death | h but not resu | Iting in the u | inderlying cause giv | en in Part I. | | | | the cause of death? |
| I Records, | The law ate has by page 2 sh | Completed by | | | | | | | 24a. Wa auto peri 1 Yes | opsy tormed? | death? | topsy findings available ompletion of cause of |
| Vital | ician: Sertific ector, | Be | 25. Was case referred to medic examiner? | Hospital: | | | nt all DOA Oth | 26. Place of Dea | ath (Check only | one) | | |
| or | Phys this ral dir | <u>۲</u> | 1 Yes 2 No 27. Manner of Death | 28a. Date of I | njury | 28b. Time o | III 3[] DOX | 4 🗀 Nursing F | lome 5 ☐ Res | | 6 □Other (Spec | cify) |
| ion | Attending r death. sctor: After by the fune | ation | 1 ☑ Natural 5 ☐ Pendi | ing (Month, i tigation | Day Year) | Injury | | ḱ? Yes 2∐No | | | , | |
| Division | l or Atte after des Directo | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter | minod 200. Flace UI | injury - At hou etc. (Specify | me, farm, st | reet, factory, office | | 28f. Location City or To | (Street ar own, State | nd Number or Ru e) | ral Route Number, |
| _ | To the Hospital or Attendil within 24 hours after death. To the Funeral Director; A completely filled in by the fu | edical | (Check only 2 ☐ Medica one) | ing Physician: To the be at Examiner: On the basi and manner | s of examinat | | nvestigation, in my | opinion, death occ | | e, date an | d place, and due | to the cause(s) |
| | vitl To | × | 29b. Signature and title of certifi | er A | | | 29c. Licens | | | 29d. Da | ite signed (Month | |
| | 20 | | 30. Name and address of person | n who completed cause of | of death (Item | 23a) (Type | Print) | D35112 | | | March 5 | , 2009 |
| | | | Paul B. Baker, | | | | | ing, Maryl | and 20910 |) | | |
| | Sta | | 31. Date filed (Month, Day, Yea. | r) 32 Regi | istrar's Signat | ure | | <u> </u> | | | | |
| | Regist | rar | MAR 10 | 2009 Certer | w B | . 40 | www. | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** taras QUO brige /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give Examiner MONT Under 1 Year | If Under on this | Days | Hours | 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 6. Sex **Funeral** Min. Months 1 □ M 2 1 1 F 80 Yrs. 209-18-3019 December 20, 1928 PA Director Usual Residence of Decedent 10d. Inside City Limits t and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3442 Chiswick Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] Vo If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ∏ Yes 2 XXXVo White Specify Specify. Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Legal Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Burt Millard Mildred Schneider 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3442 Chiswick Court, Silver Spring, MD 20906 Daniel M. Laughrige / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If iten
any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State March 9, 2009 Metropolitan Crematory Alexandria, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. West, Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2209 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performe After this certificate has 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00054566 O

State Registrar Sunitha

31. Date filed (Month, Day, Year)

Geongia

Avenu #1-17 silvers fring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bhogavilli,

9841

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dorothy Jackson Lucas 9, March 2009 1957 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Havre de Grace Harford Memorial Hospital 8. Date of Birth (Month, Day, Year)
Dec. 16, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 💢 F Yrs. 84 219-14-1856 1924 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 Nes 2 No must be notified Perryville Maryland Cecil the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6 Pages 1 and 2 should be filed within 72 hours after death with 21903 U.S.A. 541 Cecil Avenue items 23a Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X ☐ No Specify: þ 3 Widowed 4 □ Divorced White "natural" d other than "natur Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Acme Market Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. Havre de Grace, Maryland Clerk Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lydia Selik Theodore Jackson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is any injury or other trauonce. Jacqueline A. Russell (daughter) 933 Tome Highway, Port Deposit, Maryland 21904 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/13/09 |Colora, Maryland Cemetery 21. Sign ture of Funeral Service Licen se And Address of Facility
A. Patterson & Son Funeral Home, P
Perryville, Maryland 21903-0766 22. Name and Lee A. Approximate Interval Betw 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one rause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? but not resulting in the underlying cause given in Part I. þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 □ No 1 TYes 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the time. 29a. Certifier

Division or Vital Records, P.O. To the Hospital or Attending

Medical 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) GO I SOUTH UNION RVENUE, HAPRE 21078 (HARFORD MEMORIAL Registrar

and manner stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

| | | | 4 | artment of Health and Mental I | Hygiene 2009 09464 |
|---------------------|---|-------------------|---|---|--|
| | | | 1. Decedent's Name (First, Middle, Last) | 2. Date of | Death 3. Time of Death |
| | Physici /Medic | | James Abell Longmore Jr. | Month March | 16, 2009 Year 11:45 p.m. |
| - | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Death |
| ej. | | | 19692 Point Lookout Road | Lexington Park | St. Mary's |
| п | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 🕅 M 2 🗆 F | | , Day, Year) Country) |
| | Director | | 216-38-5336 | 10/22 | 1/1943 Maryland |
| | yland how | | 10a. State 10b. County 10c. City, Town or Lo | cation | 10d. Inside City Limits |
| | e Mar | Director | Maryland St. Mary's Lexington | Park | 1 ☐ Yes 2 X No |
| | ith th | Dire | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Country? |
| | s 23a | Funeral | 19692 Point Lookout Road | 20653 | United States |
| | item item | 'n. | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No | Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | No- 14. Race - American Indian, Black, White, etc. |
| 336 | hours after death with the Maryland ural", or items 23a or 28a-f show it Examinar in ural by notified at | by | 1 ☐ Never Married 2 【 Married 1 【 XYes 2 ☐ No If Yes, Give Year or Dates: | 1 □Yes 2 🛣No <i>Specify</i> : | Specify: White |
| Maryland 21215-0036 | 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", are items to notified a raumatic event, it is Medical Examinar is as by notified at | Completed | 15. Decedent's Education 16a. Dece | dent's Usual Occupation | 16b. Kind of Business/Industry |
| 21 | thin 7 ne. | nple | (Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+) | kind of work done during most of working DO NOT use retired) | |
| 121 | ed wi | | | Operator (Time) | Retail Store |
| ano | lbe fil ntal F ed ot | Be | 17. Father's Name (First, Middle, Last) | 18. Mother's Name (First, Mid | ale, Malden Surname) |
| Ĕ | ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 is marked other than "natun or other traumatic event, Its Medical | ပ | James Abell Longmore, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin | Rose T. Alvev | |
| Za | nd 2 s lith an 27 is | i | | Box 671. Leonardtown. | |
| ē, | s 1 ar f Hea f tem ; | | 20a Method of Disposition 20b. Place of Dispo | sition (Name of Date | 200 Location - City or Town, State |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. | | 1 M Burial 2 □ Cremation 3 □ Removal from State Immaculat of Mary 0 | natory or other place) Ce Heart Cemetery 03/20/2000 | Lexington Park, MD |
| alti | mit. | | | 2. Name and Address of Facility Brinsfiel | d Europeal Home D A |
| m | Depar Impor any ir | | Kyle S. Simons M01206 | 2955 Hollywood Road, Le | onardtown, MD 20650 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. | ry arrest, Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition paracrestic Ca | ncer-metastatic | Onset and Death |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | |
| | LXammer | ایرا | Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): | | |
| | nsit | Ë | cause. Enter Underlying Cause (Disease or Injury | | |
| ς, | be executed ician and burial-transit | Examiner | that initiated events c | | |
| 8760, | cate be executed obysician and the burial-transit | dical | d | | |
| 9 | | Med | IF FEMALE: | | |
| Вох | leath certific attending p for use as | an/ | 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy | ☐ Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| 0. | the a | Physician/Me | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown | Other (specify) | Month Day Year |
| σ. | hat the | | Part II. Other significant conditions contributing to death but not resulting in the ui | nderlying cause given in Part I 23e. D | id tobacco use contribute to the cause of death? |
| Records, | Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as | d by | | , , | ☐ Yes 2☐ No 3☐ Probably 4∭ Unknown |
| Ö | w requir s been s should | Completed | | 24a, W | |
| Re | : The law cate has , page 2 s | | | a | utopsy prior to completion of cause of death? |
| ta | ician: Th certificate ector, pag | | 25. Was case referred to medical | 1 ☐ Ye 26. Place of Death <i>(Check on</i> | |
| <u>></u> | Physician: this certific al director, | o Be | examiner? 1 ☐ Yes 2 MNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier | Other: | desidence 6 Other (Specify) |
| ٥ | ding Ph | اقا | 27. Manner of Death 28a. Date of Injury 28b. Time of | | be how injury occurred |
| Ö | Attending r death. ector: After by the fune | ätic | 2 Accident investigation | M 1 □Yes 2 □ No | |
| Division of Vital | I or Attend after death Director: / | Certification: To | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify) | eet, factory, office 28f. Locatio City or | n (Street and Number or Rural Route Number, Town, State) |
| | urs at eral D | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat | | |
| | 24 ho 24 ho Fun etely | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated. | n occurred at the time, date and place, and due to vestigation, in my opinion, death occurred at the tir | the cause(s) and manner as stated. ne, date and place, and due to the cause(s) |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Me | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| | . 2120 | |) Xon | D42597 | 3-17-09 |
| | ۸ | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | | J.c. |
|)d | b | | Jeffrey C. Brown, M.D. 26840 Point I | ookout Road, Leonardtov | vn, MD 20650 |
| | Sta | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | |
| | Registr | ar | NAR 19 2009 Anna A. A | ** Conflic | |

DHMH 17 Rev 1/2001

| December of the manufacture of | | | - | For State Registrar | State of | Marylan | | artment of F rtificate of I | lealth and N <i>Death</i> | | iene _{eg. No.} 🤈 (| 200 | 09165 |
|--|------|--|-----------|--|--------------------------|----------------------------------|----------------------------------|--|----------------------------------|----------------------------------|--------------------------------|-----------------------|-----------------------|
| Security of the part of the | | | | | e, Last) | | | | - | | | Voor | |
| See Sealing Name of and institution, grow showled and numbers) See See Name of See Name o | | | | James Frank L | argen, Jr. | | | | | March 1 | 7, 200 |)9 ' " | 3:01 P M |
| 5. Scale Security Number 5. Scale Security N | | | | | | ber) | | 4b. City, Town, or | r Location of Death | | 4c. Cour | • | |
| 212-80-8259 19M x CIF 51 vs. Mosthely Days Most Min 19M x 19F 190 19M x 19M x 19F 19M x 19M | - | | | | | | | | | T a B | | | |
| Too Sale No. Courty Section Too Incommon Incommon Inco | | | | 212-80-8259 | | . Age (In yrs. 51 | | | | July 4, | ^{Yea} r) 1957 | Coul | intry) |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | | yland now | | | | 10c. Cit | y, Town or Lo | cation | | | | | |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | | a-f st | ctor | Maryland S | t. Mary's | | | Leona | ardtown | | | | 1 □Yes 2 🛣 No |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | | or 28 | jre | 10e. Street and Number | | | | 10f. Zip Code | | 1 | 0g. Citizen o | f What Cou | ntry? |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | | ath wi | ra | 22495 Point Lo | | | | | | | | | |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | 036 | urs after de: al", or items | Ď | 1 Never Married 2 ☐ Marr | ied Armed Ford | es? E⊠No | | | | ecity Yes or No- Rican, etc.) | В | lack, White, | etc. |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | 5-0 | 72 ho | etec | 15. Deceden | t's Education | | I (Give | kind of work done | during most of work | | 16b. Kind of | Business/In | ndustry |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | 21 | rithin ne. ha n " | m m | Elementary/Secondary (0-12) | | for 5+) | | | d) | | Dis | sab1ed | Ĺ |
| James Frank Largen, Sr. 19th Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) | 2 | lled w Hygie her t l | | | I act) | | | ISableu | 18 Mother's Nam | e (First, Middle, I | Maiden Surn | ame) | |
| March 20, Waldorf, Maryland March 20, Waldorf, Marylan | and | d be f ental ? ed ol | | | * | | | | | | | | |
| March 20, Waldorf, Maryland March 20, Waldorf, Marylan | Z | should nd Me mark matic | ř | 19a. Informant's Name/Relations | hip (Type, Print) | | 19b. Maili | ng Address (Street | and Number or Ru | ral Route Number | r, City or Tov | vn, State, Zi | ip Code) |
| March 20, Waldorf, Maryland March 20, Waldorf, Marylan | | nd 2 salith a | | Ronnie Lee Lar | gen / Brot | her | 23552 | Myrtle I | Point Roa | d Calif | ornia, | , MD 2 | 20619 |
| 23a. Part F. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Model) and the part of the part | ore, | | | | 3 ☐ Removal from S | 20b. F | Place of Dispo cemetery, crea | sition (Name of matory or other place | വി (മ | | 20c. Locatio | n - City or T | own, State |
| 23a. Part F. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Model) and the part of the part | ţ | it. Par rtmen rtant: | | | | Tri | | | ens ¦ | | Waldorf | , Mary | land |
| Physician Medical Examiner Physician Medical Examiner Medical Cause (indicate Cause (indi | Bal | Depa Impo any I | | Michaelt | Fardi | ner | | Mattingle P.O. Box | y-Gardiner 270 Leona <u>r</u> | dtown, MD | 20650 | | |
| Immediate Cause (Final disease or condition resulting in death) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions contributing to d | | | | 23a. Part 1. Enter the disease, or shock, or heart failure. List | complications that ca | used the deat | th. Do not en | er the mode of dying | ng, such as cardiac | or respiratory arr | est, | | Interval Between |
| Sequentially list conditions, flavy, leading to minicipate the property of the | - | Physician | | Immediate Cause (Final disease or condition | | / | c f | trrhyti | mia | | | ; | 'h ' / . |
| Sequentially list conditions: Sequentially list conditions | | | | resulting in death) | Due to (c | r as a conseq | uence of): | 1/1 | - E - L | | | | |
| The control of the co | | Examiner | <u>.</u> | Sequentially list conditions, | b | 1400 | avai | al ti | hlara | 181 | | / | ninures |
| The control of the co | | ted nsit | nine | cause. Enter Underlying Cause (Disease or injury | Dae 10 10 | a consec | quence or). | | | | | | |
| The control of the co | | execu al-trar | Exar | that initiated events | c Due to (c | r as a conseq | juence of): | | | | | | |
| The state of the s | 760 | e be (| calE | | d. | | | | | | | | |
| FFEMALE: 23c. It yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) 2 Other (specify) 2 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No 3 Other 1 Yes 2 No Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other 1 Yes Yes Other | 89 | tificat g phy as the | edic | | | | | | | | | | |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 yes 2 No 3 1 yes 2 No 3 1 yes 2 No 3 1 yes 2 No 3 2 yes | | he death cer the attendin thed for use | ysician/N | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐ Live bi 4 ☐ Pregn | rth 2 Feta ant at time of | al death 3 [| | cy | | | | • |
| The composition of the complete of the compl | | that the position of the posit | | Part II. Other significant condition | ons contributing to dea | ath but not res | sulting in the u | nderlying cause giv | ven in Part I. | 23e. Did to | bacco use c | ontribute to | the cause of death? |
| 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 yes 2 No No | rds | quires in sign | | | | | | | | 1 🗆 Y | es 2 🗆 No | 3 1 Fro | bably 4 Unknown |
| 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 2 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 Impatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Date of Injury Death 1 D | Reco | The law recate has bee age 2 shoo | omplete | | | | | | | autops perfor | sy med? | prior to co death? | ompletion of cause of |
| The state The | ita | sian; ertifica ctor, p | | | I | _ | | | 26. Place of Dea | | | | |
| 27. Manner of Death 28a. Date of Injury 28b. Time of Injury | ¥ \ | hysic this co | | 1 ☐ Yes 2 ☑ No | 1 1 | • | , | III 3 LI DOA | 4 LI Nursing H | | | | ify) |
| State Registrar State Regi | n o | ing P | ion: | 1 ☑ Natural 5 ☐ Pendir | ng (Monti | f Injury n, <i>Day, Year)</i> | | Wor | rk? | 28d. Describe h | ow injury occ | urred | |
| The part of the pa | Sio | ttend death stor: / | icati | 3 ☐ Suicide 6 ☐ Could | not be | of Injury - At h | lome farm et | | Yes 2 No | 28f Location /S | treet and Nu | mber or Ru | ral Route Number |
| 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature | Div | after after I Direct | ertif | 4 ☐ Homicide detern | nined buildin | g, etc. (Speci | ify) | eet, lactory, onlo | | City or Tow | n, State) | INDEL OF THE | arriodic rumbor, |
| 29b. Signature and title of certifier 29c. License number D51398 29d. Date signed (Month, Day, Year) Morch 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar | | ne Hospita 24 hours ne Funeral stetely fille | | (Check only 2 Medical | Examiner: On the ba | sis of examin | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature | | Withil Withil Comp | M | 29b. Signature and title of certifie | 11 | 110 | | 29c. Licen: | se number | 2 | 29d. Date sig | ned (Month | , Day, Year) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) June | | | | | 2 1 | | |] | D51398 | / | Marc | h/1 | 1,2009 |
| State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | // | 5/1 | of death (Ite | m 23a) (Type | Print) 130 × 5 | 24/10 | pardtor | vn. 11 | 110 | 20h51 |
| | | | | | | gistrar's Sign | ature . | barres | - / - | | | | |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11 Mary Cross Lloyd March 2009 0355 /Medical 4a. Facility Name (If not institution, give street and number) Ctr 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Health Care Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 02 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1917 Days Months Hours Min. 1 M 2 X 220-05-4365 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Westminster 1 XYes 2 No Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 21158 USA 205 St. Mark Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. <u>Ş</u> Specify: White Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 Is marked other than " r traumatic event, the Me the M Elementary/Secondary (0-12) College (1-4or 5+) Towson YMCA 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Springer James Cross ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James S. Lloyd, Jr/son t of Health 3800 Littlestown Pike Westminster,MD Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/14/2009 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o once. XX Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Dother (Specify) 21. Sign tun of Funeral Service Licenses Princes Aftererally Home and Chapel, P.A. uch 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CAD disease or condition resulting in death) ne /Medical Due to (or as a consequence of) **Examiner** muery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 📉 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2**/**No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy certificate 2 No 1∐ Yes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1. Natural
2 Accident (Month, Day 5 Pending investigation 1 Tyes after death. 2 🗌 No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the

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> State Registrar

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29b. Signature and title of certifier

30. Name and address of per

31. Date filed (Month, Day, Year)

Abereuden Box

of death (Iter

Jasche

23a) (Type, Print)

5

29c. License number

037949

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARCH 8, 2009 MILDRED LEMPKE 11:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4457 Windy Hill Road Talbot Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 1 F Director 220-26-0334 78 June 3. 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director Maryland Talbot Trappe death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4457 Windy Hill Road 21673 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other them any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2x If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ▼No Specify Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ William T. Harris Sally Ruth Parks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lempke, Sr./husband 4457 Windy Hill Road, Trappe, Maryland 21673 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Windy Hill Cemetery 03/12/2009 Trappe, Maryland 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD 21. Signature of Funeral Service Licensee Jolley Memorial Chapel 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Betv Onetant Death Immediate Cause (Final **Physician** Vou stude disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence or): Examiner death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the a detached f P.O. law requires that the 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been sig page 2 should b 1

Yes 2

No 3

Probably 4

Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death , 2009 Year **Physician** F. Lyons Betty Jean March 5, 3:20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Wicomico Salisbury 1012 Arthur Court apt. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🖫 F 01/12/1929 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 1XIYes 2 □ No Director Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 1012 Arthur Court, Apt. 444 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) telephone operator C & P Telephone Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emanuel Armhaus Glenna B. Adkins ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111-C Linda Dr., Fruitland MD 21826 Robin Cook/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/10/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) lature of Funeral Service Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 296. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Imprediate Cause (Final TER 109 LETETIC CAR DIOVASUNLAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ ETMPHYSEMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗹 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide • To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00067916 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 SOUTH PIOISION SUITE & SMISHURT MP 21804 GUNERALEZ State

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 Marie Jeannette Long **Physician** p_M March 6, 3:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 30715 Heather Glen Drive Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/29/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 🛣 F 214-14-3990 86 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ir items 23a or 28a-f shoviling and inversignment be rediffed at 1 ☐ Yes 2 🙀 No Director Wicomico Salisbury Maryland 10f. Zip Code 21804 10g. Citizen of What Country? 10e. Street and Number 30715 Heather Glen Drive IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2**X**If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1∐Yes 2MŽNo ģ Specify: white 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) retail sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental em 27 Is marked o Mary Brandt Harry J. Lange ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30715 Heather Glen Dr., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Thomas E. Long/son 20b. Place of Disposition (Name of cemetery, crematory or other place)
WICOMICO MEMORIAL Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/11/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 22H0T10Wdy Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21 Signature of Funeral Service Licenses and St. Mongoon 23a. Part1. Enter the disease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancientia Consc disease or condition resulting in death) Cre month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Matural 5 Pending after death.

Director: Al investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/9/09 a Crus mo Dou45 995 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560 Riperside Dr. Suite JANE Salisbury, no 2150 31. Date filed (Month, Day, Year) Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician 2009 11:13a[™] Zedekiah Raphael Leatherman March 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince Georges Laurel Regional Hospital Laure1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 89 29,1920 Director 232-26-1659 Jan. Kevser. WV Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 No Yes 2 No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5264 Bright Dawn Court 21045 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Foreman 9 Construction 12 should be filed w h and Mental Hygie: 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Eugene A. Leatherman Agnes Urice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 5264 Bright Dawn Court Columbia, MD Mildred J. Leatherman/Wife 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Keyser, WV Duling Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensea Smith Funeral Home Buen 1 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed Hemahelia Due to (or as a consequence of): burial Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □ No. o. the 9 Unknown ò ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate Parkinson's Disease 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 X Natural or Attending s after deau. 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mystaileg MD D0064760 3/16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mythily Vancha, M.D. 10724 Little Patuxent Parkway, Suite 200 Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 25 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend 29c and 30 per phys. 6889 3/24/09 dk. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Robert Davidson 2009 50M March Logan, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Days Hours Yrs 715-03-4963 Director 88 16, 1920 New Hampshire Nov. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

97 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov Director MD 1 ☐Yes 2 ☑ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14008 Pennsylvania Ave. Funeral 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) $1\dot{2}$ Supervisor Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert D. Logan, Sr. ပ Florence Wilkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois M. Logan/Wife 14008 Pennsylvania Ave., Hagerstown, MD other t 21742 : If item ? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation permit. Page: Department o Important: If any injury or 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haven_Cemetery 3/14/2009 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death RESPIRATORY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, Examine n any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed CEREBRO VASCULAR ACCIDENT and as the burial-trai resulting in death) Last Due to (or as a consequence of): attending physician ATRIAL FIBRIUTION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) the □Yes 2□No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 20 No 1 □Yes 2 □No 1 🗀 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, 24 hours after death e Funeral Director: filled in by within 2

> State Registrar

Medical

31. Date filed (Month,

Mohammed S.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifie

(Check only one)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D66892

29d. Date signed (Month, Day, Year)

C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Nelson Otoniel I | | - For State | ate of Maryla | | artment of | | and Men | tal Hyg | | eg. No. 2 | 009 | 0947 | |
|---|---------------|---|--|-------------------------------|---------------------------------------|----------------------|------------------|---------------|-------------------------------------|--------------------------------------|----------------|-------------------------------------|--|
| Physici | _ | Registrar 1. Decedent's Name (First, Middl | e,Last) | • | | | 10) | | Date of Deat | th | | e of Death | |
| Medical Exami | ner | Nelson (| Otoniel | Mendo | za Me | ndoza | L/A | | Month ebruary 2 | | 05. | 29 hrs | |
| | | 4a. Facility Name (if not institution | n, give street and nun | nber) | 41 | . City, Tow | n, or Location | of Death | | 4c. County of | | | |
| | | Prince Georges Hosp | | | | Cheverly | | | | Prince Ge | | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. I | | If Under 1 Months | Year If Under | | , | th(MM/DD/YYYY) | Foreign | | |
| Director | | none | 1 X M 2 F | 3 (| O Yrs. | | | | | | Hond | uras . | |
| ý | | Usual Residence of Decedent 10a. State 10b. County | | Inc. City | Town or Location | | | | | | 10d i | nside City Limits | |
| м апу | | , | gomery | | ckvill | | | | | | l l | Yes 2 X No | |
| land land | ţō | | | | | | 1. | | 14 | 0g. Citizen of Wha | | ,,,,, | |
| Mar r 28a | Director | 10e. Street and Number 13104 Park | land Driv | | | 10f. Zip Co | 20853 | | ' | Hondu | | | |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. h is market other than "matural", or items 23a or 28a-f show a matic event, the Medical Examiner must be notified at once. | | | | | C 40 Wee | | of Hispanic Ori | nin? / Enga | fu Vos er No | | - American Ind | lian Plack | |
| ath wi tems st be | Funeral | 11. Marital Status1 Never Married 2 M | 4 1 | | .S. If Ye | s, specify C | uban, Mexicar | n, Puerto Ric | can, etc.) | White, | , etc. | | |
| er des , or i | | | 1 Yes | 2 X No | 1 7 | Yes 2 | No specify: | ndura | n | Specify: | Wh | ite | |
| 2 hours afte "natural", Examiner | ģ | 15. Decedent's Education (Spe | or Dates: | | 16a. Decedent | | | | | 16b. Kind of Bus | iness/Industry | , | |
| 2 hou "nat | tec | Elementary/Secondary (0-12) | | | during mo | st of workin | g life. DO NOT | | | | - | | |
|)36 thin 7 ne. than edica | du | 12 | | | C | ook | | | | Resta | aurant | | |
| 5-0036 iled within 7 Hygiene. I other than the Medical | Completed | 17. Father's Name (First, Middle | , Last) | | | | 18.Mothe | r's Name (F | irst, Middle, | Maiden Surname) | | - | |
| 21215-0036 Mottal Hygiene. narked other than "natural" c event, the Medical Examina | Be (| Paulino Me | ndoza | | | | Ma | ria | Melva | Mendo | za | | |
| 21 rould d Mer s mai | 10 | 19a. Informant's Name/Relations | ship (Type, Print) | | | , | | | | nber, City or Town | | | |
| ore, MD 2 ss l and 2 shou of Health and M If item 27 is n her traumatic | | Jose Diaz/ | Cousin | | | | Road | | _ | Spring | | | |
| Ore, es lan of Heal If iten | | 20a. Method of Disposition 1 X Burial 2 Cremation | Removal fro | m Ctata | Place of Disposi- crematory or oth | er place) | • | 1 | ate | San A | ntoni | 0. | |
| Pages Pages nent of ant: I | | 4 Donation 5 Other 6 | / | M | unicipa | al Ce | meter | y 3/1 | 4/20 | 09Intib | uca, H | onduras | |
| Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med | Ì | 21. Sign use of Funeral Service | | | 29 H | TLTP | dress of acily | ALDI | FUNE | ERAL SEI | RVICE | P.A. | |
| ii. ii De ထ | 5 2 | Well Dies | refle | | 92 | 41 C | olumbi | a Bl | vd.Si | lver Sp | oring, | Md20910 | |
| Physician | | 23a. Part I. Enter the disease, or failure. List only one cause | | used the death | . Do not enter th | e mode of d | ying, such as | cardiac or re | espiratory arr | est, shock, or hea | rt App Bet | roximate Interval ween Onset and | |
| / Medical caminer | | Immediate Cause (Final disease | B. A. JAim La. Links | ıries | | | | | | | | Death | |
| (annie) | | or condition resulting in death) | Due to (or as a | consequence o | of): | | 1 | | | | | | |
| | | Sequentially list conditions, | b | | 6 | | | - | | | _ | | |
| | ine | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a | consequence o | of): | | | | | | | | |
| R - | Examiner | (Disease or injury that initiated events resulting in death) Last | | | | | | | | | | | |
| executed an and all - transit | | d | | | | | | | | | | | |
| be execute | dical | UNPENDED | AMENDED | | | | | | | | | | |
| | | IF FEMALE: | | outcome of preg | nancy | - | | | | 23d. Date of | delivery | | |
| Box 6876C re death certificate the attending phys | cian/Me | 23b. Was decedent pregnant in to past 12 months? | Dress | | 41- | al death | | ic pregnanc | У | Month | Day | Year | |
| Box e death c the atten | | 1 Yes 2 No 9 Un | | ant at time of de | eath 5 Oth | er (Specify |) | | | 1 | | 4 | |
| the de | Phy | Part II. Other significant condi- | 3 Olikilo | | resulting in the u | nderlying ca | use given in P | Part I. | 23e, Did t | obacco use contril | bute to the ca | use of death? | |
| ires that the signed by t | þ | | -------------------------- | | | , | • | | 1 Ye | s 2 V No 3 | Probably | 4 Unknown | |
| IS, quires en sig | Completed | | | | | | | | 1 24a. Was | an 1 24b. V | Vere autopsy | findings available | |
| cords, law require has been see 2 should t | l be | | | | | | | | auto | psy p | | tion of cause of | |
| Rec The l | Į. | | | | | | | | 1 Yes | | ✓ Yes | 2 No | |
| of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should l | o l | 25. Was case referred to medica examiner? | | | | 26. | Place of Death | (Check on | y one) | | | | |
| Vit hysic this c | 9 9 | 1 ✓ Yes 2 No | | | ER/Outpatient | | | Nursing I | | Residence 6 | Other: | | |
| r of Viring Physic | ı. | 27. Manner of Death | 28a. Date of Month, | of Injury Day Year) | 28b. Time of Ir | | . Injury at Wor | _ le: | | how injury occurre auto auto coll | | | |
| Division tal or Attendi rs after death. al Director: / | ertification: | Natural 5 Pen Accident Inve | ding Feb 21, and stigation | 2009 | 0256 hrs | 1 | Yes 2 | No | | | | W | |
| Division pital or Attend ours after death. eral Director: | j <u>i</u> | | ld not be 28e. Place | e of Injury - At h | ome, farm, stree | t, factory, of | fice building, e | etc. 2 | 3f. Location (or Town, | (Street and Number State) | er or Rural Ro | ute Number, City | |
| Di pital ours 2 | Cerl | 4 Homicide | ermined (Specify) | Major Roa | d / Highway | | | E | US Rte 50 | just W of Route | 410, Cheve | erly, MD | |
| e Hos 24 h e Firm etely | | Consoli Silly | hysician: To the best | | | | | | | | | | |
| Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b | ledical | | aminer: On the basis of and manner st | | and/or investigati | | | | ne time, date | | | | |
| 3 | ž | 29b. Signature and title of certifi | er | 0 0 | | | icense numbe | r | 29d. Date signed (Month, Day, Year) | | | ay, Year) | |
| | | Pat- Una | m. 1 - | roll | Lus | | D.C.M.E. | | | February 2 | 1, 2009 | | |
| | | 30. Name and address of persor | | | , | | | | | | | | |
| | | Patricia Aronica-Polla | k MD. Assista | nt Medical | Examiner | 111 Pen | n Street, B | altimore, | MD 2120 |)1 | | | |
| | tate | 31. Date filed (Month, Day, Year) | 2009 32.1 | gistrar 's Si gnat | B. par | 4.1 | | | | | | | |
| Regis | trar | PAR I | 1 2003 Ken | we | p. god | | | | | | | | |

| | | For State Registrar | State of N | Maryland / Dep <i>Ce</i> | partment of Fertificate of | | - | giene () | 09 | 09473 |
|---|----------------|--|---------------------------------------|--|--|--|---|----------------------------------|-------------------------------|---|
| | | 1. Decedent's Name (First, Middle, | Last) | | | | 2. Date of De | ath | | 3. Time of Death |
| Physici | | | Larel Earl | McKenzie | | | Month | Day 02 | Yeer 2009 | 9:30 pm |
| /Medic | | 4a. Facility Name (If not institution, | | | 4b. City, Town, o | r Location of Dea | | | nty of Death | |
| Examin | ıer | | | | , | | | 10.000 | | |
| | | Springbrook Advent 5. Social Security Number 6 | | Home Age (In yrs. last birthda) | | Silver Spi ∣∥fUnder24 Hr | | th | | gomery lace (State or Foreign |
| Funeral | | | 1⊠M 2□F | Vrc | Months Days | Hours Min | n. (Month, Da | y, Year) | Cour | itry) |
| Director | | 578-80-8075 Usual Residence of Decedent | | 68 | | | June 17 | , 1940 | Jamai | ca, W.I. |
| land | | 10a. State 10b. County | | 10c. City, Town or I | ocation | | | | 1 | 0d. Inside City Limits |
| dary est | 5 | Managar day Man | | | C | flores Com | | | | 1 ☐ Yes 2 ☑ No |
| the the | Director | Maryland Mo: 10e. Street and Number | ntgomery | | 10f. Zip Code | ilver Spri | Liig | 10g. Citizen o | of What Cour | un/2 |
| be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, The Medical Examinar must be notified at | | | | | 101. Zip 0000 | | | rog. Onizen c | | • |
| s 23 | Funeral | | ockhart Place | | W Bd(II | 20902 | (Casalta Van an Na | 14.0 | U.S. ace - Americ | |
| er de Hem | nu | 11. Marital Status | 12. Was Decede Armed Force | | . Was Decedent of H If Yes, specify Cuba | an, Mexican, Pue | specify tes of No erto Rican, etc.) | - 14. R | lack, White, | |
| or or | by F | 1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give | | 1 ☐ Yes 2 ☒ No | Specify: | | Spec | oify: | |
| incom | | | Year or Date | | | | | 405 16'-4-4 | D | Black |
| "nat | Completed | 15. Decedent's (Specify only highest | | (Giv | edent's Usual Occup e kind of work done DO NOT use retired | during most of w | orking | 16b. Kind of | Business/Inc | dustry |
| han han | E D | Elementary/Secondary (0-12) | College (1-4d | or 5+) | | • | | | a | •• |
| lygie her t | | 12. 17. Father's Name (First, Middle, La | | | Warehousema | | | | 2 | s House |
| d ot | Be | 17. Fathers Name (First, Middle, La | 3 57) | | | 18. Mother's N | ame (First, Middle, | Maiden Sum | ame) | |
| should ind Men marke umatic | P | | n McKenzie | | | C1 | larissa Cor | a Willia | ms | |
| and ls m | | 19a. Informant's Name/Relationshi | p (Type, Print) | 19b. Mai | ling Address (Street | and Number or F | Rural Route Numbe | er, City or Tow | m, State, Zip | Code) |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. I Important: if them 271 is marked other than 'natural', or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinar must be notified at once. | | Terra E. Douglas | - Daughter | 1150 | 1 Lockhart | Place, Sil | lver String | , Maryla | nd 2090 | 2 |
| oth oth | | 20a. Method of Disposition | | 20b. Place of Disp cemetery, cri | position (Name of ematory or other place | ce) | Date | 20c. Location | n - City or To | wn, State |
| age ent c nt: it | | 1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe | | te | leaven Cemete | | /21/2009 | Cilver | Saring | , Maryland |
| artmoortar ortar injur | | 21. Signature of Funeral Service Li | 1 | The second secon | 22. Name and Addre | | 21/2009 | SIIVEL | Shrring | , maryrand |
| Depar Impor any ir | | too we did | 0011/09 | H | lines-Rinald: | i Funeral | Home, Inc. | | | 1 00004 |
| | | 23a. Part1. Enter the disease, or c | Serves | | .1800 New Har | | | | g, Mary | 1and 20904 Approximate |
| | | shock, of heart failure. List or | nly one cause on each | line. | nter the mode of dyin | ig, such as carul | ac or respiratory ar | 1651, | | Interval Between Onset and Death |
| างร่างเล่า | | Immediate Cause (Final disease or condition | a Cardia | ac Arrythymia | | | | | | Instant |
| Medical | | resulting in death) | _ | as a consequence of): | | | | | | |
| kaminer | | Conventially list conditions | _{b.} Cardio | omyorathy | | | | | | 3 months |
| ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | as a consequence of): | | | | | | |
| physician and s the burial-transit | Examiner | Cause (Disease or injury that initiated events | C | | | | | | | |
| n an ial-tr | Exa | resulting in death) Last | Due to (or | as a consequence of): | | | | | | |
| sicia e bur | dlcal | | d | | | | | | | |
| phy s thr | edic | | | | | | | | | |
| attending p | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | | | 23d [| Date of delive | erv. |
| atte | ciai | in the past 12 months? | | | ☐ Ectopic pregnancy ☐ Other (specify) | , | | | | Day Year |
| the ched | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□ Unknown | | | | | | | |
| signed by the a Id be detached f | | Part II. Other significant condition | s contributing to death | but not resulting in the | underlying cause giv | en in Part I | 23e. Did to | obacco usa co | ntribute to th | e cause of death? |
| signe bed | by | | | | and only mig deduce give | J | | | | ably 4 ⊠Unknown |
| should | ted | Hypertension | | | | | '0' | 2 140 | | abiy 4 Monkhown |
| 2 5 | ompleted | Diabetes Mellit | us | | | | 24a. Was autop | | . Were autor | psy findings available appletion of cause of |
| leath. tor: After this certificate has the funeral director, page 2 | E | End Chass Dansi | Diagona | | | | perfor | rmed? | death? 1 ☐ Yes | |
| tifica tor, p | e C | End Stage Renal 25. Was case referred to medical | Disease | | | 26. Place of Dr | eath (Check only o | | | |
| s cer direc | 0 | examiner? 1 ☐ Yes 2 ☒ No | Hospital: 1 Inpa | atient 2 ER/Outpatie | ent 30 DOA Oth | | Home 5 ☐ Resid | | ther (Specific | () |
| n. After this certifica funeral director, | F | 27. Manner of Death | 28a. Date of Ir (Month, I | | of 28c. Injur | | 28d. Describe h | | | 7 |
| within 24 hours after death. To the Funeral Director; After completely filled in by the fune | ţ | 1 X Natural 5 ☐ Pending 2 ☐ Accident investiga | | Day Year) Injury | | k? Yes 2.⊡No | | | | |
| after death. Director: A I in by the fu | Certification: | 3 Suicide 6 Could no | t be Ogo Blood of | Injury - At home, farm, s | treet factory office | | 28f. Location (S | Street and Nun | nber or Rura | l Route Number |
| ojre Dire in b | iti | 4 Homicide determin | building, | etc. (Specify) | 11001, 1201019, 011100 | | City or Tou | vn, State) | | 11001011001, |
| eral illed | | Con Conting 157 Conting | Dhusisian Table be | -4 -6 | | | 1 | | | |
| Fun Fun | edical | (Check only 2 Medical E) | ceminer: On the basis | st of my knowledge, dea of examination and/or i | ith occurred at the tin nvestigation, in my o | ne, date and plac pinion, death occ | ce, and due to the c curred at the time, c | cause(s) and r date and place | nanner as st e, and due to | ated. the cause(s) |
| within 24 hours after of To the Funeral Direct completely filled in by | | one) | and manner | stated. | | | | | | |
| 100 100 100 | Σ | 29b. Signature and title of certifier | | | 29c. Licens | e number | | 29d. Date sigr | ied (Month, l | uay, Year) |
| | | The | | | D | 28656 | | March | 3, 200 |)9 |
| | | 30. Name and address of person w | ho completed cause o | f death (Item 23a) (Type | , Print) | | | | | |
| | 1 | Ravi Pacci M D | 15225 Shar | dy Grove Road, | #208 Rocks | ville Mar | vland 2085 | 0 | | |
| 44791 | | Ravi rassi, m.D | · · · · · · · · · · · · · · · · · · · | a) or over modely | #200, ROCK | ville, imi |) I a | 0 | | |
| Sta | ate | 31. Date filed (Month, Day, Year) MAR 1 0 2 | 2 Page | strar's Signatura | | ville, nai | . , 14114 2003 | | | |

State of Maryland / Department of Health and Mental Hygiene) 09474 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** March 9, Charles Frederick Matson 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ManorCare Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Mar 27, Birthplace (State or Foreign Country) **Funeral** 1√M 2□F 1924 Director 481-32-5731 84 Iowa Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumetic event. It a Medical Examiner must be natified at Director 1 ☐ Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3316 Harrell Street 20906 or Items 23e USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: If item 27 is marked other then "neturel", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Biochemist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Charles Matson Gertrude Rylocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary P. Matson/wife 3316 Harrell Street Silver Spring, MD 20906 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 03/11/09 Odenton, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atrial Fibrillation resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebralvascular Accident Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner tospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Dementia that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Chronic Obstructive Pulmonary Disease IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Yea 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ funeral director, page 2 should be Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainler as stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) MBonne D59649 March 9, 2009 ALF) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechukwu D. Mbonu, M.D. 9501 Old Annapolis Rd. #302 Ellicott City, MD 21042 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

State Registrar

TLS

10+VA

ST, MICHARUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

51

32. Registrar's Signature

S. TALBOT

336

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** March 16, Mary Jones Mura 7:50 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 29950 Holmes Road **Mechanicsville** St. Mary's 8. Date of Birth July, Year 930 New York ocial Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Days 111-24-5813 **78** Hours 1 M 2 X Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Tennessee Smith Riddleton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37151 USA 72 Wilburn Hollow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc.
White 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2^{College (1-4or 5+)} Elementary/Secondary (0-12) Administrative Assistant Xerox 18. Mother's Name (First, Middle, Maiden Surname)

Edna M. Sweet 17. Father's Name (First, Middle, Last) Be John Paul Jones 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29950 Holmes Road, Mechanicsville, MD 20659 Barbara J. Fleming/Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Brinsfield-Echols Crem. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 18, Charlotte Hall, MD 22. Name and Address of action of Europe P.A. Brinsfield Echols Funeral Home, P.A. P.O. Box 128 Charlotte Hall, MD 20622 MO0817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due lo (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ

Physician /Medical Examiner

any Ir

Funeral

Director

ns 23a or 28a-f sh must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

aftending physician and

signed by the

certificate

this

eral Director: A

within 24 hours a

To the Funeral 6

To the Hospital of Attending Physician:

Completed

Be

၉

Certification:

Medical

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy perform 20

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

| | | _ |
|----------------------|-----------------|---|
| 6. Place of Death (C | Check only one) | |
| 4 ☐ Nursing Home | 5 Residence | 6 |

Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

1 Inpatient

(Month, Day Year)

28a. Date of Injury

29c. License number

Other:

28c. Injury at Work?

20622

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE

Hospital:

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

egistrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MAR 8 DAVAUN JELEEL MYLES 2009 7:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8. Date of Birth (Month, Day, Months 2 Days Hours Min. 2009 XXM 2□ F Maryland 218 83 2201 Jan 8, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Suitland 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20746 United States 6315 Suitland Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2/CYNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes XX No Specify. ģ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Jonathan Myles Monique S. Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6315 Suitland Road, Suitland, MD 20746 Myrna D. Jackson (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of March 13, Dat 2009 cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Sign ture of uneral Service Ols Alexandria Ferry Road, Clinton, MD 23a. Part 1. Ente shock, or e, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. the dise Approximate Interval Between Onset and Death Immediate Couse (Fin) EXTREME PREMATURITY disease or andition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any health to invest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 ♥ No 25. Was case referred to medical Be Medical Certification: To

Examiner To the Hospital or Attending Physician: The law requires that the ceath certificate be executed Division of Vital Records, P.O. Box 68760,

physician and s the burial-trans attending p been signed by the should be detached cate has page 2 s funeral After ours after death.

neral Director: Af
filled in by the fur within 24 hours a

Funeral

Director

28a-f shov

r than "natural", or Items 23a or 28a-f shov the Wolcal Examiner must be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monce.

Physician

/Medical

Items 23a

o

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

| examiner? | | Ed. 1 lade of Beath (Sheek ethy one) | | | | | | | | | | |
|--|---------------------------------------|---|---|---------------------|---|--|---|--|--|--|--|--|
| 1 ☐ Yes 2 🔀 I | No | Hospital: 1 X Inpatient 2 □ |] ER/Outpatient | 3 🔲 DC | A Other: 4 \(\sum \) Nursin | ng Home 5 ☐ Re | sidence 6 ☐ Other (Specify) | | | | | |
| 27. Manner of Death 1 XNatural 2 Accident | 5 ☐ Pending investigation | | 28b. Time of Injury | M 2 | Bc. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe | e how injury occurred | | | | | |
| 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could not be determined | 28e. Place of Injury - At h building, etc. (Speci | ome, farm, street, | factory | office | 28f. Location City or To | (Street and Number or Rural Route Number, own, State) | | | | | |
| 29a. Certifier (Check only one) | 1 ☑ Certifying Ph 2 ☐ Medical Exam | ysician: To the best of my knoniner: On the basis of examination and manner stated. | owledge, death or ation and/or inves | ccurred tigation | at the time, date and p in my opinion, death | place, and due to the control occurred at the time | ne cause(s) and manner as stated. e, date and place, and due to the cause(s) | | | | | |
| 29b. Signature and | title of Certifier | 0// | | 290 | License number | | 29d. Date signed (Month, Day, Year) | | | | | |
| 1 | 7m/ | /n_ N | n_ MD | | | (VA) | 3/10/2009 | | | | | |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RYAN T. MOORE MAJ

MAR 122009

31. Date filed (Month, Day, Year)

MC USA

32. Pégistrar's Signature parked neur

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State

Registrar

DB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State | | State of Ma | arylan | | irtment of <i>tificate of</i> | | Mental H | | 2 H H Q | 09478 |
|--------------------------------|--|------------------|--|--|--|-----------------------------------|--|---|---|--------------------------------------|---------------------------|---------------------------------------|--|
| | | | Registrar 1. Decedent's Name | e (First, Middle, Las | t) | | | | Dealli | 2. Date of D | | | 3. Time of Death |
| | Physici /Medi | | James | Michael | | W | | | | Febru | Day ary 2 | Year 7 2009 | 4:30 A. M |
| | Examir | ner | 4a. Facility Name (h | fnotinstitution, give | | | | 4b. City, Town, Potoma | or Location of Deat | h | 4c. | County of Death | |
| | Funeral | Г | 5. Social Security N | umber 6. Se | x 7. Ag | | ast birthday) | If Under 1 Year Months Days | If Under 24 Hrs | 8. Date of E | | Iontgomes 9. Births | olace (State or Foreign |
| | Director | | 220–34–77 Usual Residence of | 01 | XM 2□F | 69 | Yrs. | IVIOITUIS Days | Hours Min. | 8. Date of E (Month, I NOV • | 2, 19 | 39 Washi | place (State or Foreign otry) Lngton, D.C. |
| | yland how | | 10a. State | 10b. County | | 1 | , Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| | he Mar 8a-f s | ecto | MD | Montgome | ry | Pot | omac | | | | | | 1 Yes 2 No |
| | 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examinar must be notified at | Funeral Director | 10e. Street and Num 11900 Fr | ost Valle | y Way | | | 10f. Zip Code 20854 | 1 | | | zen of What Cour .ted Stat | • |
| | r death | nera | 11. Marital Status | | 12. Was Decedent I | Ever in U.S | S. 13. V | | Hispanic Origin? (S pan, Mexican, Puer | Specify Yes or N | | 14. Race - Americ | can Indian, |
| 36 | rs afte | by Fi | 1 Never Marrie | _ | 1 ⊠ Yes 2 🔲 N | ₀ 1957– | | ☐Yes 2 No | | io i tiodii, etc.) | | Black, White, Specify: Whi | |
| 2-00 | 72 hou natura lical E | eted | | 15. Decedent's Edu | cation | - | 16a. Deced | ent's Usual Occu | pation | | 16b. Kir | nd of Business/Inc | dustry |
| 121 | within ene. | Completed | Elementary/Secon | | College (1-4or 5 | +) | Owner | io not use retire (General | pation during most of word) Manager | king | Ele | ctronics | Co. |
| d 2 | il Hygid other | Be Co | 17. Father's Name (| | 4 | | | | 18. Mother's Nar | ne (First, Middl | e, Maiden | Surname) | |
| ylar | ould be Menta arked attc ev | 고 B | Charles 1 | Marvin Mc | Graw, Jr. | | | | Julia 1 | Elizabe | th Br | own | |
| Mar | d 2 shoth and the and the shoth should be shou | | 19a. Informant's Na | me/Relationship (T) McGraw/W: | | | 1 | | t and Number or Ru | | | | Code) |
| re, | s 1 an of Heal item 2 | 2 | 20a. Method of Disp | osition | | 20b. Pi | ace of Dispos | tion (Name of | Valley Way | Potor Dates | mac, M | D 20854 cation - City or To | wn, State |
| Baltimore, Maryland 21215-0036 | Page ment (ant: If | | 1 □ Burial 2 □ 4 ☑ Donation | Cremation 3 ☐ F 5 ☐ Other (Specify) | Removal from State | Med | | ition (Name of Flory Prother old enter enter | 1 | Dat 27 09 | 1 | hington, | |
| Ball | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Fur | neral Service Licens | enf. | | 22 | Name and Address 9013 An | ess of Facility Co. napolis I | lumbia M Rd. Lank | Mortuanam, 1 | ary Serv MD 20706 | ices, P.A. |
| | 100 | | 23a. Part 1. Enter th shock, or hear | e disease, or compl t failure. List only or | ications that caused ne cause on each lin | the death. | Do not ente | | | | | | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (F disease or condition resulting in death) | Final | Multiple | | | | | | | | Onset and Death |
| | Examiner | | | | Pathalog | - | | ıre | | | | | |
| B | ed sit | iner | Sequentially list con- cause. Enter Under Cause (Disease or in | ditions, rediate lying | Due to (or as a | nonseque | moe offy: | | | 7.57 | | | |
| * | execut n and al-tran | Examiner | that initiated events resulting in death) La | | Due to (or as a | a conseque | ence of): | | | | | | |
| 68760 | ficate be executed physician and s the burial-transit | edical | | | d | | | | | | | | |
| 20x 68 | leath certific attending pl | /Med | IF FEMALE: | | 3c. If yes, outcome of | of pregnan | CV | | | | | | |
| S res | death e atten d for u | Physician/M | 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ | nonths? | 1 ☐ Live birth 1 4 ☐ Pregnant at | 2 🗌 Fetal (| death 3 🗌 | Ectopic pregnand Other (specify) _ | СУ | | 2. | 3d. Date of delive Month | ry Day Year |
| F.0. | uires that the de signed by the d be detached t | Phys | 9 ☐ Unknown | | 9 Unknown | | | | | 0 | | | • |
| Worlste He's | res ti | ρ | Part II. Other signific | cant conditions cor | ntributing to death bu | t not resur | ting in the un | lerlying cause giv | en in Part I. | | | | e cause of death? |
| Records | e law requir has been si e 2 should b | Completed | | | | | | | | 24a. Was | | 24b. Were autop | osy findings available |
| 3 " | The ate h | Com | | | | | | | | auto perfe 1 □ Yes | ormed? 2 ☑No | prior to con death? 1 ∐Yes | npletion of cause of 2 □No |
| हिर Vital | sician certifi rector | Be | 25. Was case referred examiner? 1 ☐ Yes 2 ☒ N | | lospital: | | 5/0 / | 3 🗆 DOA Oth | 26. Place of Dea | | | | |
| 100 | ig Phys ter this neral dir | n: To | 27. Manner of Death | | 28a. Date of Injur | y 2 | R/Outpatient 28b. Time of Injury | 28c. Injui | 4 L Nursing H | ome 5X Res 28d. Describe | | Other (Specify occurred | ") |
| SA(b)OL Division | tendir leath. tor: Af the fur | catio | 2 ☐ Accident 3 ☐ Suicide | 5 ☐ Pending investigation 6 ☐ Could not be | | | | M 1 🗆 | Yes 2 □ No | | | | |
| 234(b)OK | Hospital or Attending Physician: 44 hours after death Funeral Director: After this certificitely filled in by the funeral director; to | Certification: | 4 Homicide | determined | 28e. Place of Injui building, etc. | ry - At hon . <i>(Specify)</i> | ne, farm, stre | et, factory, office | | 28f. Location (City or To | (Street and wn, State) | Number or Rural | Route Number, |
| 275 | To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di | Medical (| 29a. Certifier (Check only one) | Certifying Phys □ Medical Examin | sician: To the best o ner: On the basis of and manner stat | examination | ledge, death on and/or inv | occurred at the ti estigation, in my o | me, date and place opinion, death occu | , and due to the rred at the time | e cause(s) , date and | and manner as st place, and due to | ated. the cause(s) |
| 20 | Vithin To th | Me | 29b. Signature and ti | | 1 - P | . 0 | 21 | 29c. Licens | |) | | signed (Month, E | |
| 0 | ν | - | | 0 | ucitche | , | | | 63742 | / | March | 1 5, 2009 | 9 |
| | | | 30. Name and addres | | mpleted cause of de itchou, M. | • | | | caster Mi | 11 Rd. | . Rocl | kville M | 20855 |
| | Stat Registra | G | 31. Date filed (Month | | 22. Registra | r's Signatu | par | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Z:50 P. M MAR Svetlana Manzhukh 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 28, 1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F Yrs. 60 Director Russian Federation 214-37-9471 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inter 17 item 27 is marked other then "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 ☑ No by Funeral Director Maryland Montgomery Derwood 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16112 Crabbs Branch Way, Apt. #22 20855 U.S.A. 12. Was Decedent Ever in U.S. Amed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 None N/A other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Iosif Manzhukh Mira Gelfand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irina Goodman - Sister 1782 Vickers Circle, Decatur, Georgia 30030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If i 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 □ Other (Specify) Garden of Remembrance 03/11/2009 Clarksburg, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HISOPHRENIA 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed POSTTRAUMATIC 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No BRAIN SYNDROME CHRONIC OKGANIC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other 4 | Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral C Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number D 572 8 4 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAR 9 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6105 MONTROSE ANNO FORAN, MD ROCKVILLE MD 20852 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Tingle Marshall Helen 2009 07 3:16 P March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days 218-50-1959 98 09/23/1910 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 9288 Hickory Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No ò Specify: white 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Etha Belle Truitt James Henry Tingle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27569 Pemberton Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Richard Marshall/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery 3/10/09 Salisbury, MD of Euperal Service L Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 art . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death iate Cause (Final disease or condition resulting in death) EMENTIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 UNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

requires that the death certificate be executed sician and burial-tran Division or Vital Records, P.O. Box 68760, physician for ed by the detached signed k been certificate has page 2 Hospital or Attending Physician: director, this After death.

death with the Maryland

72 hours after

Baltimore, Maryland 21215-0036

show

"natural", or items 23a or 28a-f shov idical Examiner must be notified at

Medical

the M

Department of Health and Mental Hygiv Important: If Item 27 Is marked other any Injury or other traumatic event, tt

Hygiene.

2 should be fi and Mental F

Pages 1 and 2 should I

n 24 hours after death.

Per Funeral Director: A pletely filled in by the files. completely To th.
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To the Fu

State

Registrar

Medical

29b. Signature and title of certifier Maesha Thimmarayappa,

4 Homicide

(Check only one)

29a, Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 614 Eastern Shore Dr., Salisbury, MD 21804

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

gistrar's Signatu

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Gertrude Marshall 1502 M MARCH 2009 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death • NIOMICO 544564144 FENINSULA REGIONAL MEDICAL If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. 216-07-5790 1 □ M 2**X** F Months Days Hours 95 06/15/1913 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Delaware Sussex Delmar 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 Delaware Ave. 19940 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: white 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Bookkeeping 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Marshall Effie Sterling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith M. Bailey/granddaughter 606 Delaware Ave., Delmar, DE 19940 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crisfield Cemetery 3/9/09 Crisfield, MD 5 ☐ Other (Specify) of Funeral Service M 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 VD disease or condition resulting in death) Due to (or as a consequence of): CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **(1)**No 2 No 1 ☐ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Ø DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner

Physician

/Medical

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at

72 hours after death with

d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n.

Pages 1 and 2 sl ment of Health an ant: If item 27 is

permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

Exami Physician/Medical þ Completed Be

Certification: To

ical

3 Suicide

29a, Certifier (Check only

4 Homicide

6 Could not be determined

The law requires that the death certificate be executed attending physician for use as the buria signed by the a page 2 should has certificate **Physician**: After this or Attending death. Director: completely filled in by after within 24 hours a To the Funeral I To the Hospital

Box 68760.

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Records,

of Vital

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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57952 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hilford ST. #504B. Salisbury. MD 21804 Das

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

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| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Denastrated of Health and Maryla Hurispa | n control of the cont | Oliver |
| sion of Vital Records, P.O. Box 68760, | ttending Physician: The law requires that the death certificate be executed death. | tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit | |

| | | 1 | For State Registrar | Otate of Wi | ai yiaira | | rtificate of | | | | eg. No. | | 0 7 4 0 1 |
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| Phy | ; siciar | | Decedent's Name (First, Middle, Decedent's Name (First, Midd | Last) Trving | Marra | | | | | 2. Date of Deat Month Februar | | o Year o | 3. Time of Death |
| /M | edica mine | 1 | Paul ¹ 4a. Facility Name (If not institution, | | Morga | ın | 4b. City, Town, | or Locatio | | rebruar | | , 2009 | 9:30pm M |
| LAG | mine | | 12822 Martin F | | | | Smith | ısbur, | g | | | rederic | k |
| Fune Direc | _ | | 5. Social Security Number 213-12-7848 Usual Residence of Decedent | 3. Sex 7. Ag 1 X 2 M 2 □ F | e (In yrs. la. | st birthday) Yrs. | If Under 1 Year Months Days | | er 24 Hrs. Min. | 8. Date of Birth (Month, Day, Dec. 6, | Year) 1921 | Cour | lace (State or Foreign try) yland |
| yland | ā | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| e Mar | | ב ב | | derick | | Smi | thsburg | | | | | | 1 □ Yes 2 🛣 No |
| with th | First ville os rounes | | 10e. Street and Number | D. 7 | | | 10f. Zip Code | 0.750 | • | 1 | 0g. Citize | n of What Cour | try? |
| death ms 23 | | ם ב | 12822 Martin 11. Marital Status | 12. Was Decedent | Ever in U.S. | 13. | Was Decedent of f Yes, specify Cul | 2178 | | cify Yes or No- | 14 | U.S.A. | an Indian, |
| 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show | A by Eu | 2 | 1 ☐ Never Married 2 【XMarrie 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: | No | | f Yes, specify Cul | | | iican, etc.) | Sį | Black, White, on the second se | etc. hi te |
| 72 hc | loto! | ומומ | 15. Decedent's (Specify only highest | Education grade completed) | | 16a. Dece | dent's Usual Occu kind of work done DO NOT use retire | pation during m | ost of working | 9 | 16b. Kind | of Business/Ind | dustry |
| withir rithan | Completed | <u>.</u> | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | ane Oper | | | | | Aircra: | ft |
| tal Hyg | Svenit, | | 17. Father's Name (First, Middle, La | • | · · · · · · · · · · · · · · · · · · · | | | | | (First, Middle, N | | ırname) | |
| d Men | | | Ralph Emerson | | | 401 14 111 | | | | Brand e n. | | | |
| nd 2 sl alth an 27 is r | | | 19a. Informant's Name/Relationship Vera Morgan (W | if e) | | | ng Address (Stree Martin | | | | | | Code) |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any inition or other than "natural". | | 1 | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe | | 20b. Pla St,cer | ce of Dispo | sition (Name of Batory or ether pl metery | | Feb. 2 | 22, | 20c. Loca | tion - City or To | |
| permit. Departm | once. | 1 | 21. Signature of Funeral Service Li | | MO14. | 22 | . Name and Addr | | cility | 12 | 525 I | Bradbury | a Ave. |
| 4 90F | 5 OI | 4 | 23a. Part 1. Enter the disease, or co | e Davis | | J | .L. Davi | | | Home Sm | <u>i_thsl</u> | ourg,Md | .21783 |
| Physici /Medio | _ | | shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) | nly one cause on each lir | oscler | otic | Cardiova | | | | 351, | | Approximate Interval Between Onset and Death Years |
| Examin | ■. | | Sequentially list conditions, | b | | | | | | | | | |
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| rtificate be executed ng physician and as the burial-transit | | | that initiated events resulting in death) Last | c. Due to (or as | a conseque | nce of): | | | - | | | | |
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| attendir | M/agi | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown | 2 Fetal d | eath 3 | Ectopic pregnan Other (specify) | ісу | | | 230 | d. Date of delive | ry Day Year |
| that the dended by the adetached | | | Part II. Other significant condition | s contributing to death be | ut not resulti | ing in the u | nderlying cause gi | ven in Par | t I. | 23e. Did tob | acco use | contribute to th | e cause of death? |
| w requires to been signer should be a | 2 | | | | | | | | | 1 □ Ye | s 2[X | No 3□ Prob | ably 4 Unknown |
| The law recate has been | [| | | | | | | | | 24a. Was ar autops perforn 1 □ Yes 2 | y ned? | 24b. Were autor prior to cor death? 1 ∐Yes | osy findings available npletion of cause of |
| lysician: T lis certifical director, pa | Re |) | 25. Was case referred to medical examiner? | l Hawket | | | I o | | ce of Death (| Check only one | 2 5 | I Lies | 2 1110 |
| - X S | Į. | ٠ ا | 1 X Yes 2 ☐ No 27. Manner of Death | Hospital: 1 Inpatie 28a. Date of Inju (Month, Da | | R/Outpatier 8b. Time of | I 3 L DOA | | | e 5 Reside | | Other (Specify |) |
| Attending Physician: r death. ector; After this certification the funeral director. | it | | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat | | y, Year) | Injury | 28c. Inju Wo M 1 | rk?]Yes 2[| | | w injury o | ocurred | |
| tal or Atters all Directors of in by the | Certification. | | 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine | | ury - At hom c. (Specify) | e, farm, str | eet, factory, office | | 28 | If. Location (Sti City or Town | reet and N , State) | lumber or Rura | Route Number, |
| To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral | Medical | | 29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Certifying | Physician: To the best caminer: On the basis o and manner sta | f examinatio | edge, deatl on and/or in | occurred at the vestigation, in my | time, date opinion, d | and place, ar eath occurred | nd due to the ca | ause(s) ar ate and pla | nd manner as si ace, and due to | ated. the cause(s) |
| To ti Vithi To ti | Σ | | 29b. Signature and title of certifier | liver M | DD | ME | 29c. Licen | se numbe 7197 | r | -Z | ad. Date s F ebru Cecem | igned (Month, L Lary 19, ber 19, | 2009 2009 |
| , | | 3 | 30. Name and address of person what Alan H. Rohrer | | | | | Face | ndont of | z Mana- | 1050 | 01701 | 4501 |
| | State istrar | | Alan H. Rohrer 31. Date filed (Month, Day, Year) | 32 Begietre | | ΄Δ | | , 116 | euerich | k, Mary | <u> rand</u> | Z1/U1- | +JUL |
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| | | 1 - For State of Maryland / E | Department of Health and N Certificate of Death | | ene g. No. 2009 | 09483 |
|--|---------------------|--|--|--|--------------------------------------|---|
| | dical | 1da Newman | 4b. City, Town, or Location of Death | 2. Date of Death Month March 8 | | 3. Time of Death 10:45 a ^M |
| Funer | | Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bir | Bethesda | 8. Date of Birth (Month, Day,) 11/01/19 | Year) 9. Birthp | tgomery lace (State or Foreign |
| | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | Rockville 10f. Zip Code 20852 | | | 0d. Inside City Limits 1X Yes 2 □ No |
| 10 21215-0036 Filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show fent, the Medical Examination. | Completed by Funera | 3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) | 16 | 14. Race - Americ Black, White, e | an Indian, etc. White |
| | Be | 17. Father's Name (First, Middle, Last) | Homemaker | e (First, Middle, Ma | Own iden Surname) | Home |
| e, Maryland t and 2 should be f Health and Mental I em 27 is marked of ther traumatic eve | 2 | 19a. Informant's Name/Relationship (Type. Print) Ruth Matt, daughter 58 | Mailing Address (Street and Number or Rur. 01 Nicholson Lane #18 | al Route Number, C | City or Town, State, Zip | ^{Code)} 20852 |
| timor t. Pages tment of tant: If it | once. | 1 Seurial 2 Cremation 3 Removal from State | Disposition (Name of y, crematory or other place) Memorial Gdns 03/1 22. Name and Address of Facility Edward Sagel Funeral 1091 Rockville Pike | 1/2009 0 | Iney, Mary | land |
| hypoticial by the private property of the private priv | ıl | 23a. Part Enter the disease, or complications that caused the death. Do nearly shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of the conditions) of the conditions of | not enter the mode of dying, such as cardiac of the mode of the mo | or respiratory arresi | t, | nd 20852 Approximate Interval Between Onset and Death |
| the death certific ty the attending parties as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant In the past 12 pronths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | 23d. Date of deliver | ry Day Year |
| w requires that the de s been signed by the s should be detached i | Completed by Pl | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause given in Part I. | | 2 No 3 Proba | |
| ding Physician: The law h. After this certificate has funeral director, page 2: | Be Comp | 25. Was case referred to medical examiner? | 26. Place of Death | autopsy performed 1 ☐ Yes 2 ☐ | prior to com death? | pletion of cause of |
| the Hospital or Attending Physician: The law requires that the death certifin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending impletely filled in by the funeral director, page 2 should be detached for use as | Certification: To | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ mpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of Injury 28b. T | ime of jury at Work? M 1 Yes 2 No | 28d. Describe how i | at and Number or Rural | |
| To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: A completely filled in by the tu | Medical Cer | 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and | death occurred at the time, date and place, to investigation, in my opinion, death occurred. | and due to the caused at the time, date | co(c) and manner so et | ated. the cause(s) |
| To the To the comple | Mec | 29b. Signature and title of eriginer | 29c. License number | | Date signed (Wonth, D | |
| S Regis | tate trar | 30. Name and address of person who completed cause of death (Item 23a) (1 Dr. Atul Rohatgi, 9901 Medical Cent 31. Date filed (Month, Day, Year) WAR 11 2009 | ter Drive, Rockville, | Maryland | 20850 | |

DHMH 17 Rev 1/2001

BUS

NEWHAN IDA

| | | State of Maryland / Department o 1 - State Registrar Certificate of Maryland / Department of Certificate of Maryland / Department of Certificate of Certif | f Health and M | - | ne ₂ nng | 09484 |
|--|-------------------------------------|--|--|--|--|---|
| Physici /Medic Examin | al | 1. Decedent's Name (First, Middle, Last) Catherine C. O'Brien | n, or Location of Death | 2. Date of Death Month March 20 | Day Year | 3. Time of Death 6:30 a.m. |
| Funeral Director | C. | $\begin{array}{c ccccccccccccccccccccccccccccccccccc$ | 1ywood ar If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye | St. Mar | |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment matches notified at once. | To Be Completed by Funeral Director | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland St. Mary's Hollywood 10e. Street and Number 43265 Rosalind's Drive 20 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 11 □ Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Total Printly Michael McDevitt 19a. Informant's Name/Relationship (Type. Print) Kathleen Rongione/Daughter 10c. City, Town or Location Hollywood 10f. Zip Cod 18. Was Decedent Ever in U.S. Armed Forces? 11 □ Yes 2 ☑ No 11 □ Yes, specify 0 11 □ | of Hispanic Origin? (Specuban, Mexican, Puerto In Specify: cupation and during most of working the during the during th | 10g. cify Yes or No-Rican, etc.) (First, Middle, Maic E1 I Route Number, Ci , Hollywo | USA 14. Race - Ame Black, White Specify: Wob. Kind of Business. Dwn Home den Surname) ichel ity or Town, State, 200d, MD 2 Location - City or neltenham | 10d. Inside City Limits 1 □ Yes 2 ▼ No Duntry? Prican Indian, e, etc. hite Industry Zip Code) 0636 Town, State PA |
| ate be nysicia | dical Examiner | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c | dying, such as cardiac o | r respiratory arrest, | | Approximate Interval Between Onset and Death |
| hat the death certificate by the attending physicate detached for use as the the | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify, 9 Unknown) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (specify, 9 Unknown) |) | 23a Did tohaco | 23d. Date of del Month | ivery Day Year |
| Ital Hecords, P.O. ian: The law requires that the rifficate has been signed by the rtor, page 2 should be detache | Completed by | 25. Was case referred to medical | | 1 □ Yes 24a. Was an autopsy performed: 1 □ Yes 2.4 | 2 No 3 Pr 24b. Were au prior to death? | obably 4 □ Unknown topsy findings available completion of cause of |
| ng Physic ng Physic fter this ce | Certification: To Be | examiner? 1 Yes 2 No | njury at 2 /ork? □Yes 2□No | (Check only one) ne 5 Residence 8d. Describe how in 8f. Location (Street City or Town, Str | njury occurred and Number or Ru | |
| To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical | | ny opinion, death occurre | 29d. I | and place, and due Date signed (Month | to the cause(s) |
| Stat Registra | ır | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | , builte 200 | , Leonard | LOWIL MID | 20650 |

ORIGINAL

| | | | For State Registrar | State of Ma | ryland | | artment of I | | | lental Hy | giene 2 Reg. No. | 009 | 09485 |
|---------------------|--|-------------------|---|--|-------------------|------------------------|---|----------------------|-----------|---------------------------|---------------------|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Las | et) | | | | | | Date of De Month | ath Day | Year | 3. Time of Death |
| - | /Medic | | | es Marvin | Pott | er, S | | | | March | 12 | 2009 | 0640 A ^M |
| | Examin | ier | 4a. Facility Name (If not institution, give | | | | 4b. City, Town, o | | of Death | | | unty of Death | |
| - Park | | | 609 East Pulaski 5. Social Security Number 6. So | | (In vrs. la | ast birthday | E1ktor | | 24 Hrs. | 8. Date of Bir | th | ecil | place (State or Foreign |
| | Funeral Director | | | M 2□F 88 | | Yrs. | Months Days | Hours | Min. | May 7, | av, Year) | Cou | intry) rginia |
| | D | | Usual Residence of Decedent | | | | | | | | | | |
| | show | _ | 10a. State 10b. County | | - | , Town or L | ocation | | | | | | 10d. Inside City Limits 1 1 Yes 2 □ No |
| | be Ma | Director | Maryland Cecil | | E | 1kton | 404 75-0-4- | | | | 10- 04 | 1 11/1 1 0 1 | 71 |
| | a or S | Ö | 10e. Street and Number | *** 1 | | | 10f. Zip Code | | | | _ | of What Cou | |
| | eath | Funeral | 609 East Pulaski | Highway 12. Was Decedent E | ver in U.S | S. 13. | 21921 Was Decedent of I | | iain? (Sp | ecify Yes or No | | ited S | |
| (D | r iten | Fun | 1 Never Married 2 Married | 12. Was Decedent E Armed Forces? 1 XYes 2 N | $_{\circ}$ Wor1 | d | Was Decedent of I | | | Rican, etc.) | | Black, White, | |
| 03 | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinat must be notified at | l by | 3 X Widowed 4 □ Divorced | If Yes, Give Year or Dates: | War | II | 1⊡Yes 2∏XNo | Specify: | | | Sp | pecify: W | hite |
| 21215-0036 | 72 hc | Completed | 15. Decedent's Ed (Specify only highest gra | | | 16a. Dece (Give | dent's Usual Occu kind of work done DO NOT use retire | pation during mos | t of work | ing | | of Business/Ir | • |
| 121 | within iene. than " | du | Elementary/Secondary (0-12) | College (1-4or 5- | -) | | | nd) | | | | mobile | |
| d 2 | filed v Hygid Sther i | | 9 17. Father's Name (First, Middle, Last) | | | FI | achinist | 18. Mothe | er's Name | e (First, Middle | | factur | Ing |
| an | d be ental ked o | To Be | Romules L. Potter | | | | | Clar | a R | Martir | 1 | , | |
| ary | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examinar must be natified at | - | 19a. Informant's Name/Relationship (| _ | | 19b. Mail | ng Address (Street | | | | | own, State, Zi | p Code) |
| Σ | 1 and 2 Health a em 27 ls | | Hazel Sue Butler/ | Daughter | | 609 | East Pula | aski H | lighw | ay, Elk | ton, | MD 219 | 921 |
| ore | ges 1 aint of Hear If item or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Danis and from Chat- | 20b. Pl | ace of Disp | osition (Name of matory or other pla | ce)_ N | March | n 16, | 20c. Locat | ion - City or T | own, State |
| Ē | nit. Pages artment of I ortant: If ite injury or or | | 4 Donation 5 Other (Specify | | ∣ Mou | nt La | wn Memori Gardens | al 3 | 2009 | . | Во | one, N | C |
| Baltimore, Maryland | permit. Pages Department of Important: If i any injury or once. | | 21. Signature of Funeral Service Licen | see | _ | H | 2. Name and Addre | ess of Facilit | Fune | erals. 1 | P.A. | | |
| | <u>σ</u> □ ≒ α οι | | Doniel | S. Hick | 1) | | 03 W. St | ocktor | SEI | reet, E | <u>lkton,</u> | MD 2 | 1921 |
| | | | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only | | | . Do not en | ter the mode of dyi | ng, such as | cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death |
| - | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a Leng | // | Fall | ure | | | | | | >3years |
| 1 | Examiner | | | Due to (or as a | consequ | ence of): | | | | | | | |
| | | ē | Sequentially list conditions, if any, leading to immediate cause. Liner Unidenying Cause (Disease or injury | b. Due to (or as a | consequ | ence of): | | | | | | | |
| | cuted Id ansit | Examiner | Cause (Disease or injury that initiated events | C | | | | | | | | | |
| o, | e exectan ar | | resulting in death) Last | Due to (or as a | consequ | ence of): | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medical | | .d | | | | | | | | | |
| 20 20 | eath certific attending p for use as t | Mec | IF FEMALE: | 000 15 100 0140000 | | | | | | | T | | |
| Box | attend for us | ian | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at | 2 🗀 Fetal | death 3 | Ectopic pregnan | су | | | 23d | Date of deliver Month | very Day Year |
| o | the de | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9 ☐ Unknown | ume or ue | eatri 5 | Other (specify) _ | | | | | | |
| σ. | w requires that the d been signed by the should be detached | | Part II. Other significant conditions of | ontributing to death bu | t not resu | Iting in the u | inderlying cause gi | ven in Part I | | 23e. Did t | obacco use | contribute to | the cause of death? |
| of Vital Records, | quires in sign | d by | Coronary arte | ry disea | el, | atric | 1 6hg | lato | n | 1 🗆 ' | Yes 2□N | No 3□ Pro | bably 4 Unknown |
| O O | aw rei as bee 2 shoi | olete | hunertension. | anemi | 0 | , (4 | F. CO | PD | , | 24a. Was | | 4b. Were auto | opsy findings available |
| Ä | iclan; The lav certificate has ector, page 2 | Completed | | | | | | 4_4_4_ | | autop perfo 1 □ Yes | ormed? 2 No | death? | ompletion of cause of 2 □No |
| ita | stan; ertifica ctor, p | Be C | 25. Was case referred to medical examiner? | | | | | | | h (Check only o | one) | 17:112 | |
| ž V | hysic this ca Il dire | ၉ | 1 Yes 2 No | | | | III 3 DOA | ner: 4 🗆 Nu | ursing Ho | me 5 🗆 Resi | dence 6 X | Other (Speci | Daughter's R esidence |
| n c | ling F | io iii | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injur (Month, Day | Year) | 28b. Time of Injury | Wo | rk? | | 28d. Describe | how injury o | ccurred | |
| isio | Attending Physician; r death. ector: After this certifics by the funeral director, p | icat | 2 Accident investigation 3 Suicide 6 Could not be | | ry - At hou | me farm et | | Yes 2 | No | 28f Location (| Street and N | lumber or Bur | al Route Number, |
| Division | l or A after Direct I in by | Certification: | 4 ☐ Homicide determined | building, etc. | (Specify | () | cot, tactory, office | | | City or To | wn, State) | amber or Har | ai riodie ivaliibei, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | | 29a. Certifier 1 Certifying Ph | ysiclan: To the best o | f my knov | wledge, dea | th occurred at the t | ime, date a | nd place, | and due to the | cause(s) ar | id manner as | stated. |
| | he Ho in 24 I he Fu pletel | Medical | (Check only 2 Medical Examone) | niner: On the basis of and manner stat | | tion and/or i | vestigation, in my | opinion, dea | ath occur | red at the time, | date and pla | ace, and due t | to the cause(s) |
| _ | vith Com | Σ | 29b. Signature and title of certifier | | | | 29c. Licen: | se number | | | | igned (Month, | |
| | | | 11/2/ | 14 MD | | | DOO | 593 | 24 | / | Marc | h 12, | 2009 |
| Ĺ | LHVA | | 30. Name and address of person who | completed cause of de | ath (Item | 23a) (Type | Print) | 11 / | 111 | | | • | |
| | , , | • | 31. Date filed (Month, Day, Year) | 32. Registra | 74h r's Signat | ture | JUIK SI | 4 61 | KTOP | 1, MD | 219 | \(\sigma\) | |
| | Sta Registr | | MAR 1 2 2009 | | 1 | bar | Ke | | | | | | |

| | State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 0 9 0 9 4 8 6 | | | | | | | | | | | | | |
|---------------------|---|-------------------|--|------------------------------------|------------------------------------|--|--------------------------|---|-----------------------------------|---|--------------------------|---|--|--|
| | | | Registrar 1. Decedent's Name (F | First Middle La | ant) | | Ce | illicate of t | Jealii | 2. Date of D | Reg. No | 2007 | | |
| | Physici | an | | | , | | | | | Month | Da | y Year | 3. Time of Death | |
| a. | /Medi | | Diana Lyn | | | | | 4h City Town on | Location of C | March | 1 | | 3:15 a ^M | |
| | Examir | ier | 4a. Facility Name (If no | _ | | | | 4b. City, Town, or | ninste | | 40 | . County of Death Carro | 1 | |
| | | | Carroll Ho 5. Social Security Numb | - do | | | s. last birthday) | If Under 1 Year | If Under 24 | | lirth | | Lace (State or Foreign | |
| | Funeral Director | | 213-60-4900 | | 1 | r. Age (III yi | 57 Yrs. | Months Days | | Min. (Month, I | 04 (Oay, Year) | 1051 Cour | itry) MID | |
| | | | Usual Residence of De | | | | 31 | | | Duly | 04 | 1934 | FID | |
| | ylanc III | | 10a. State 10 | b. County | | 10c. 0 | City, Town or Lo | | | | | 1 | 0d. Inside City Limits | |
| | Mar a-f sl | Director | MID | Carro | 011 | | West | ninster | | | | | 1 ☐ Yes 2 ZMNo | |
| | h the | ire | 10e. Street and Numbe | er | | | | 10f. Zip Code | | | 10g. Ci | tizen of What Coun | try? | |
| | th wit | <u>a</u> | 2296 W. Va | alley La | ane | | | 21 | 158 | | | USA | | |
| | dea | Funeral | 11. Marital Status | - | 12. Was Dece | | U.S. 13. | Was Decedent of Hi f Yes, specify Cuba | spanic Origin | ? (Specify Yes or N | 10- | 14. Race - Americ | | |
| 98 | or it | 正 | 1 Never Married | 2 Married | 1 □Yes If Yes, Gi | 2 X No | | 1 ⊡Yes 2 ⊠XNo | Specify: | derio modifi, etc.) | | Black, White, | | |
| 00 | 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examitrat must be rodified at | d by | 3 ☐ Widowed 4 ☐ | Divorced | Year or D | ates: | | | | | | Specify: Wh | ite ————— | |
| 5- | "nati | Completed | 15. (Specify o | . Decedent's E only highest gra | ducation ade co <i>mpleted)</i> | | (Give | dent's Usual Occupa kind of work done of | luring most of | working | | ind of Business/Ind Lomer Ser | | |
| 12 | within ene. | E G | Elementary/Seconda | ry (0-12) | College (1 | -4or 5+) | | DO NOT use retired Superviso: | , | Joseph A. Bank | | | | |
| d 2 | Hygi Hygi ther | ပ္သ | 17. Father's Name (Firs | st. Middle. Last |) | | | July Control | | Name (First, Middl | | | | |
| Maryland 21215-0036 | d be ental ced o | o Be | Robert Car | | | | | | | Shae | o, | our rainey | | |
| Ξ | should mark | 은 | 19a. Informant's Name | | Type Print) | | 19h Mailir | ng Address (Street a | | | her City | or Town State 7in | Cadal | |
| | nd 2 g | | Dale W. Ped | | | Westmin | . , | | | | | | | |
| ē, | f Hear f Hear tem | | 20a. Method of Disposit | | | 13%2009 | | ocation - City or To | | | | | | |
| Baltimore, | permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiliar must be notified at once. | | 1 ☐ Burial 2 🖾 C 4 ☐ Donation 5 ☐ | | 13/2009 | H: | ampstead, | MID | | | | | | |
| ₹ | artm ortar Injur | | 21. Signature of Funera | | ** | , Inc | ome and C | | | 1-115 | | | | |
| B | permi Depar Impol any Ir | | Youle X | 20- | | | | oad West | | | 21157 | | | |
| | | | 23a. Part 1\ Enter the d shock, or heart fa | disease, or com | plications that o | | | JOZ / 12 | Approximate | | | | | |
| | Physician | 6 95 | Immediate Cause (Fina | | | | たから | Brea | | Pancen | | | Interval Between Onset and Death | |
| | /Medical | | disease or condition resulting in death) | - | a | or as a conse | | IPrea | 57 | aheen | | | | |
| | Examiner | | | 1 | 500.0 | , or as a consc | rquerioe oi). | | | | | | | |
| | | je l | Sequentially list condition if any, leading to immediate | ons, diate | Due to | or as a conse | quence of): | | | | | | | |
| | cuted nd ansit | Examine | cause. Enter Underlyin Cause (Disease or injuithat initiated events | ry S | C | | | | | | | | | |
| o, | an ar rial-tı | | resulting in death) Last | | Due to | or as a conse | quence of): | | | | | | | |
| 8760, | icate be executed physician and s the burial-transit | dical | | | d | | | · | | | | | | |
| | rtifica ng ph as tl | ab i | IF FEMALE: | | | | | | | | | | | |
| Box | eath certific attending p for use as | an/ | 23b. Was decedent pre | | 23c. If yes, out | come of prego oirth 2□Fe | | Ectopic pregnancy | , | | | 23d. Date of delive | | |
| . E | e dea he at ed fo | Physician/M | in the past 12 mor | o ptns? | | nant at time of | | Other (specify) | | | | Month | Day Year | |
| P.0 | at the de | Ph | 9 Unknown | | | | | | | | | | | |
| Ś | res tha signed be det | | Part II. Other significar | nt conditions o Voらと | | | sulting in the u | nderlying cause give | n in Part I. | | | use contribute to th | | |
| Records, | w requir been s should | ted | | VUAE | Kno | Wh | | | | 1L | Yes 2 | □ No 3 □ Prob | ably 4 \ Unknown | |
| ec | e 2 sh | ple | | | | | | | | 24a. Wa | s an opsy | 24b. Were autop | osy findings available inpletion of cause of | |
| = | : The I | Completed by | | | | | | | | j per | ormed? 2 ∑ 4No | death? | | |
| of Vital | slclan: The certificate rector, pag | Be (| 25. Was case referred t | to medical | | • | | | | Death (Check only | | | | |
| 1 | Physic this c | | 1 ☐ Yes 2 No | | | · . | ☐ ER/Outpatier | t 3 DOA Othe | r: 4 🗆 Nursir | ng Home 5 ☐ Res | sidence | 6 Cother (Specify | Inpatient | |
| Ē | ding P h. After 1 funera | Certification; To | 27. Manner of Death 1 Natural 5 | Pending | 28a. Date (Mon | of Injury h, Day, Year) | 28b. Time of Injury | Work | | 28d. Describe | how injur | y occurred | 717 | |
| sio | Attendi death. ctor: / y the fu | cati | 2 Accident | investigation | | | | 1 | es 2□No | | | _ | | |
| Division | or At fter of pirect in by | Ħ | 4 ☐ Homicide | determined | 28e. Place | of Injury - At I ng, etc. (Spec | home, farm, str cify) | eet, factory, office | | 28f. Location City or To | (Street an wn, State | d Number or Rura) | Route Number, | |
| | Hospital or Attending Physician: The law requires that the death certificate hours after death. 24 hours after death. 25 hours after death. 26 hours after death. 27 hours after death. 28 hours after death of the attending telly filled in by the funeral director, page 2 should be detached for use as | | 00-0-46 | 300 | 4 | | | | | | | | | |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical | 29a. Certifier 12 (Check only 20 one) | Medical Exar | niner: On the b | best of my kr asis of examir ner stated. | nation and/or in | n occurred at the time vestigation, in my op | ie, date and p pinion, death o | place, and due to the occurred at the time | e cause(s e, date and |) and manner as st d place, and due to | ated. the cause(s) | |
| | of the omple | Me | 29b. Signature and title | of certifier | and man | ioi stateg. | | 29c. License | number | | 29d. Da | te signed (Month, I | Dav. Year) | |
| | WIL | | 14m- | -l 1 | witi | m D. | | | 2-57-5 | | | 3/10/0 | | |
| | MA | | 30. Name and address | of nerson who | completed favo | e of death (Its | am 23a) (Tune | Print) | | | | | | |
| | 1 | | Howard | Ja ion | tz M.I | | S Sou | th Cente | er St | West | Lusin | ster m | 1 21157 | |
| | Sta | te | 31. Date filed (Month, D | Day, Year) | 32. R | e istrar's Sign | nature | | | | | • | | |
| | Registr | - 1 | M | AR 12: | 2009 | news | B. 1 | arkel | | | | | 1 21157 | |
| DH | /IH 17 Rev 1/20 | 201 | | | | | 1 | | | | | | | |

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9^{Day}2009^{Year} March 0220a = M Poon Hoi /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maris Nursing Facility Timonium If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 8/22/ Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 219-90-8586 China **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at MD Charles Director 1 XYes 2 □ No Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20601 2305 Springbrook Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. after 1 Never Married 2 Married , o. 21215-0036 1 ☐Yes 2 No Specify: Completed by Specify: Asian 3 Widowed 4 Divorced within 72 hours "natural", 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Developer Private <u>12th</u> Important: If item 27 is marked other any Injury or other traumatic event, I Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname)
Chow Fon Yuan æ Pages 1 and 2 should be 1 nent of Health and Mental Guang Lin Poon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yuen Kay Poon/Daughter 2023 Mock Orange Ct. Reston, VA. 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 3/22/09 Falls Church, VA. National Mem. of Funeral Service Licer 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physiclan: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate perform Vital 2XINo 1 □ Yes 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director: After t 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 24 hours a Funeral [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and matrix as stated.

Nurse Practitioner within 2 To the 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 133/ JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 122009 Registrar

DHMH 17 Rev 1/2001

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 935 M Lee Porter March /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Hospital Baltimore, MD 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Director 220-70-6053 52 JAN. 8, 1957 MARYLAND Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evanting must be notified at Director 1 ☐ Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 HARFORD ROAD 21666 UNITED STATES Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 9m 27 is marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify <u>Ş</u> Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) MECHANICAL College (1-4or 5+) Elementary/Secondary (0-12) 10 OWNER SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ CHARLES PORTER JUNE HOSTJBOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr SHARON PORTER/WIFE 114 HARFORD ROAD, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 MARCH 11 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY STEVENSVILLE, MARYLAND 2009 FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician septicemi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed Exami burial-transi and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) n signed by the a P.O. 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 1 No the Hospital or Attending Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. 2 Accident investigation 1 ☐Yes 2 ☐ No Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after die Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the within 7 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) AU4176435118926 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Green oatvam as

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GA DEN MONTGOMERY Bethesda If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🗵 F Yrs Director 577-52-4482 96 November 17,1912 New York Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 🖾 No Directo Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 U.S.A. 5550 Tuckerman Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the NIH Medical Administrator 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Feld Sara Scherzer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7601 N. 10th Street, Phoenix, Arizona 85020 Stuart Phillips - Son item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/09/2009 <u>Adas Israel Cemetery</u> Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner ARDIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi TROKE resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year signed by the aid 2**5**(Vo 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 20 No Hospital: Other: မှ 1 ☐ Yes 3□ DOA 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1. Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State Registrar

D

Day, MAR 11 2009

ANAGO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated Med

29d. Date signed (Month, Pay, Year)

| | | | For State Registrar | | State of Ma | aryiand | | artment of F rtificate of | | | | giene? Reg. No. | 2009 | 09490 |
|--|--------------|------------------|--|-----------------------------|--|--|---------------------|---|------------------|--|----------------------------|---------------------------|---|--|
| Phy | ysicia | n | 1. Decedent's Name (First | | , | | | | | 2 | . Date of De Month | ath Day | Year | 3. Time of Death |
| | /ledic | | Garland Pin | | | | | | | | 03 | 06 | 2009 | 12:00p M |
| Exa | amin | er | 4a. Facility Name (If not in: Bedford Cou | - | , | | | 4b. City, Town, o | | | | | County of Death | |
| Fund | orol | . 2 | 5. Social Security Number | | | e (In vrs. la | st birthday) | If Under 1 Year | - | 24 Hrs. 8 | Date of Bir | th | ontgome | |
| Direc | | | 578 - 38-4189 | · | I ⊠ M 2□F | 91 | Yrs. | Months Days | Hours | Min. | (Month, Da 5/17/1 | y, Year) 917 | Coun | lace (State or Foreign try) |
| put | e la | | Usual Residence of Deced | lent County | | 10c City | Town or Lo | cation | | | | | 14 | 0d. Inside City Limits |
| Maryla f sho | ed at | ٥. | | ntgome | rv | | ver Sp | | | | | | | od. mside City Limits 1½ Yes 2 □ No |
| the 1 | notif | rec | 10e. Street and Number | | | 011 | ver br | 10f. Zip Code | | | | 10g. Citize | en of What Coun | itry? |
| th with | st pe | Funeral Director | 15101 Inter: | lacher | n Drive | | | 20906 | | | | Unite | ed State | · · · · · · · · · · · · · · · · · · · |
| r dea | er m. | ner | 11. Marital Status | | 12. Was Decedent 8 Armed Forces? | ver in U.S | 13. \ | Was Decedent of H | Hispanic Ori | igin? (Specif | | | 1. Race - Americ | an Indian, |
| s afte | gwin Gwin | by Fu | 1 ☐ Never Married 2 3 ☑ Widowed 4 ☐ Di | | 1 X Yes 2 ☐ N If Yes, Give Year or Dates:1 | lo. | | I □ Yes 2 No | | | , , , , | | Black, White, Afri Afri Specify: | |
| -UUSO | Sa E | ed h | 15. De | ecedent's E | ducation | 945 | 16a. Deced | lent's Usual Occup | oation | | - 1 | 16b. Kind | Amer of Business/Inc | ican |
| 7 iii ° iii i | Media | Completed | (Specify only Elementary/Secondary (| / highest gra | ade completed) College (1-4or 5 | +) | (Give life. L | kind of work done OO NOT use retired | during mos d) | t of working | | | | , |
| ked with | t, the | Sol | | | 4 | | Busin | essman | | | | Priv | | |
| be file | even | Be | 17. Father's Name (First, In Greene Fort | . , | | | | | l | er's Name <i>(F</i> 1 e11a I | First, Middle, | Maiden S | urname) | |
| hould d Mer marke | natic | ၉ | 19a. Informant's Name/Re | | | | 10h Mailin | - Addus - (Ot | | | | | | |
| IVICA nd 2 sl lith an 27 is r | tran | | Garland F. | | | n l | | g Address (Street 16th Str | | | | | | • |
| s 1 ar if Hea | othe | - | 20a. Method of Disposition | | | | | sition (Name of natory or other place | | Date | | | ation - City or To | |
| mit. Pages partment of portant: If it | ا ایک | ij | 1X Burial 2 □ Crem 4 □ Donation 5 □ O | | | | | k Cemete | 1 | 3/13/2 | 2009 | Washi | ington, | DC |
| pairiniore, interpriation 2 12 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show | any Inju | | 21. Signature of Funeral S | Service Lice | nsee | | | . Name and Addre | | | | unera | al Servi | ce, Inc. |
| 0 885 | g 0 | 7 | Unche | Sh | orpson | | | 400 Geor | | | | | ngton, D | C 20012 |
| | | 20 | 23a. Part1. Enter the dise shock, or heart failur | ase, or com e. List only | | | | | | | | rest, | | Approximate Interval Between Onset and Death |
| Physic /Medi | | | Immediate Cause (Final disease or condition resulting in death) | - | a | | | Cardiova | scula | r Dise | ease | | | Years |
| Exami | | | | | Due to (or as a | a conseque | ence or): | | | | | | | |
| | | ner | Sequentially list conditions if any langer in the cause. Enter Underlying Cause (Disease or injury | | Due to (or as a | conseque | ence of | | | | | | | |
| ecuter | trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | c | | | | | | | | | |
| tificate be executed g physician and | puriai | E E | resulting in death, East | - 1 | Due to (or as a | conseque | ence of): | | | | | | | |
| ficate be ex | s lie | edical | | | _d | | | | | | | | | |
| | Tor use a | | IF FEMALE: 23b. Was decedent pregna | ant | 23c. If yes, outcome | | | | | | | 23 | d. Date of delive | rv |
| death death | TOT DE | Physician/M | in the past 12 months 1 ☐ Yes 2 ☐ No | | 1□Live birth 4□Pregnant at 9□Unknown | | | Ectopic pregnancy Other <i>(specify)</i> | y | | | | | Day Year |
| res that the de | eracu | Phys | 9 Unknown | | | | | | | | | | | |
| signed | ag | 2 | Part II. Other significant of Congestive I | | - | | • | , , | | | | | | e cause of death? |
| w require been signaled by | SHOULE | eted | | | | | | draf Acc | <u> </u> | • | 1 U Y | | | ably 4 □Unknown |
| he law | | Completed | Failure to | TIIT TAE | , Dementia | | | | | | 24a. Was a autop | | 24b. Were autor prior to con death? | esy findings available apletion of cause of |
| an: T tificate | o. | | 25. Was case referred to n | nedical | | | | | 26 Place | of Dooth (C | | 2 🔀 No | | 2 □ No |
| Physician: The is rithis certificate has | | 0 | examiner? 1 ☐ Yes 2🌠 No | | Hospital: 1 ☐ Inpatier | nt 2 🗆 El | R/Outpatient | : 3□ DOA Oth | | | | | ☐Other (Specify |) |
| ding Ph After th | <u>g</u> | ü | 27. Manner of Death 1 X Natural 5 | Pending | 28a. Date of Injur (Month, Day | y Year) 2 | 28b. Time of Injury | 28c. Injur Worl | | | . Describe h | | | / |
| tendi leath. tor: A | | catio | 2 Accident | investigation | | | | M 1 🗆 | Yes 2□ | - | | | | |
| after death Director: | ka II | Certification: | | determined | 28e. Place of inju building, etc | ry - At hom . <i>(Sp</i> ec <i>ify)</i> | ie, farm, stre | et, factory, office | | 28f. | Location (S City or Tow | Street and I n, State) | Number or Rural | Route Number, |
| spital | | | 29a. Certifier 1 ☒ Ce | ertifying Ph | ysician: To the best o | f my knowl | ledge, death | occurred at the tir | me, date an | nd place, and | I due to the | cause(s) a | nd manner as sta | ated. |
| To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending boundaries in white funeral director mans 2 should be datased for any | biener) | Medical | (Check only 2 Moone) | edical Exar | niner: On the basis of and manner sta | examinatio | on and/or inv | estigation, in my o | ppinion, dea | th occurred | at the time, | date and p | lace, and due to | the cause(s) |
| | | Σ | 29b. Signature and title of | , | VIA Sin | Ja | | 29c. License | e number | | 2 | 29d. Date s | signed (Month, E | Day, Year) |
| 5+ | 1 | | | | unon | WIV | | D53 | | | | | h 9, 20 | 09 |
| | | | 30. Name and address of p 9801 Georgia | | | | | | msund | | an, M | .D. | | |
| 2 - 32 | Stat | e | 31. Date filed (Month, Day, | | 32. Registra | r's Signatu | re | | , MD | 20902 | | | | |
| Reg | gistra | - | MAR 1 | 1 200 | 9 Bentus | A. | par | | | | | | | |

| | | | For State Registrar | | State o | f Mary | land / Depa <i>Ce</i> | artment of <i>rtificate o</i> | | | | giene Reg. No.2 | 09 | 09491 |
|--|--|---------------|--|--------------------------|----------------------------|--|--------------------------------------|---------------------------------------|-----------------------------|---------------|---------------------------------|--------------------|--|--|
| | Dhoois | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of D Month | | | | V | 3. Time of Death | |
| | Physici /Medi | | | В | arbara An | n Pete | r | | | | March | Day O1 | Year 2009 | 6:25 pM |
| | Examir | | 4a. Facility Name (If not instit | ution, giv | re street and nu | mber) | | 4b. City, Town | , or Location | n of Death | | 4c. Count | y of Death | 1 |
| | | | Washington | Adven | tist Host | ital | | | Takoma | a Park | | | Montgo | merv |
| | Funeral | | 5. Social Security Number | 6. 5 | Sex | | yrs. last birthday) | If Under 1 Year Months Day | ar If Unde | er 24 Hrs. | 8. Date of Bir (Month, Da | th | 9. Birthp | place (State or Foreign |
| | Director | | 217-70-2897 | _ 1 | □ M 2⊠ F | | 96 Yrs. | Wortins Day | rs nours | | November | | Coui | ryland |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventher must be notified at once. | | Usual Residence of Deceden | | | | | | | | | | | |
| | | _ | 10a. State 10b. Cou | inty | | 100 | c. City, Town or Lo | cation | | | | | 1 | 0d. Inside City Limits |
| | Ba-f s | cto | Maryland Pri | nce G | eorge's | | | | Adelphi | | | | } | 1 □Yes 2 ☑ No |
| | if th | Director | 10e. Street and Number | | | | | 10f. Zip Code | 9 | | | 10g. Citizen of | What Cour | ntry? |
| | th w | | 8811 Riggs | Road | | | | | 2078 | 33 | | | U.S.A | • |
| | ems ems | Funeral | 11. Marital Status | | 12. Was Dec | | | Was Decedent of Yes, specify Co | f Hispanic (uban, Mexic | Origin? (Spe | ecify Yes or No Bican, etc.) | | ce - Americ | |
| 98 | afte or it | Y F | 1 Never Married 2 | | 1 ∐Yes If Yes, Gi | | | 1∐Yes 2⊠N | | | | Speci | | 510. |
| 21215-0036 | ural" | d by | 3 ☑ Widowed 4 ☐ Divor | ced | Year or D | ates: | | | | | | Speci | iy. | White |
| Ŋ | 72 h | ete | 15. Dece (Specify only hi | dent's Ed ghest gra | ducation ade completed) | | (Give | dent's Usual Occ kind of work dor | ne durina mo | ost of workir | ng | 16b. Kind of E | Business/Ind | dustry |
| 121 | vithin the. than | Be Completed | Elementary/Secondary (0-1 | 2) | College (| 1-4or 5+) | life. | DO NOT use reti | , | | | | | |
| | led v Hygie her t | ပိ | 12 | -ttta | | | | Homema | | | (F) N. 1.11 | | Own Hor | me |
| an o | be find he fin | | 17. Father's Name (First, Mid | | | | | | 18. MOT | | | Maiden Surna | me) | |
| Ĕ | ould d Me nark | ٩ | | | k Funk | | | | | | Agnes And | | | |
| <u>a</u> | 12 st h an 7 Is n traur | 9.4 | 19a. Informant's Name/Relat | | | | 19b. Mailir | ig Address (Stre | et and Num | iber or Rura | I Route Numbe | er, City or Town | n, State, Zip | Code) |
| <u>ئ</u> | l and Healt HE 2: | - | Pamela Casagran | da - (| Granddaug | | | Greenwood | | | | | | |
| ō | ges it of l | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremati | on 3□ | Removal from | State | Ob. Place of Dispo cemetery, crer | sition (Ivame of natory or other p | lace) | Đ | ate | 20c. Location | - City or To | wn, State |
| ŧ | t. Pa timer tant: jury | | 4 □ Donation 5 □ Othe | - | | | Fort Linco | | | 03/14 | /2009 | Brentwoo | d, Mar | yland |
| Baltimore, Maryland | permi Depar mpor Iny Ir | | 21. Signature of Funeral Serv | ice Licer | see Od | + | Н | . Name and Add ines-Rina: | ldi Fun | eral Ho | ome. Inc. | | | |
| | 20 = 2 g | | 23a. Part 1. Enter the disease | 1.0 | e cerco | 1 | 1 | 1800 New I | Hampshi | re Aver | nue, Silv | er Sprin | g, Mary | y1and 20904 Approximate |
| 1 | Physician /Medical Examiner | ner | shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any reading to immediate cause. First Indexing. | List only | Due to | (or as a | sequence of): | ntic | ulo | r | b1 | eld | | Interval Between Onset and Death |
| ₽, 68 | icate be executed physician and the burial-transit | ŭΙ | it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 1 | C | | | | | | | | | |
| Box 68760, | The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit | /Medical | IF FEMALE: 23b. Was decedent pregnant | | d23c. If yes, out | | | TOTAL | - | | | 234 D | ate of delive | NEW . |
| P.O. B | t the death by the atter ached for u | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | | nant at time | | Ectopic pregna Other (specify) | | | | | | Day Year |
| | w requires that the d been signed by the should be detached | ρ | Part II. Other significant con | ditions c | ontributing to de | eath but no | t resulting in the ur | derlying cause o | given in Part | · I. | | | | ably 4 Unknown |
| of Vital Records, | | Completed | | | | | | | | | | rmed? | Were autor prior to cor death? 1 □Yes | osy findings available inpletion of cause of |
| Vit | certil ecto | 8 | 25. Was case referred to med examiner? | ical | Hospital: | / | | 10 | the are | | (Check only or | | | |
| o | Phys this al dir | 은 | 1 ☐ Yes 2 ☐ Ho | | 1 🗖 | | 2 ER/Outpatier | 1 3 L DOA | | | | lence 6 □Oti | |) |
| L C | ding Physiclan: 1. After this certific funeral director, | <u>ö</u> | 27. Mann of Death 1 Natural 5 ☐ Per | nding | | of injury th, Day, Yea | 28b. Time of Injury | 28c. Inj | | | 8d. Describe h | ow injury occur | red | |
| Division | Attending Physiclan: r death. sctor: After this certifici | licat | 3 ☐ Suicide 6 ☐ Cor | estigation ald not be | | of Injury - | At home farm str | | □Yes 2□ | | 9f Location (6 | Street and Mount | has as Dura | l Route Number, |
| To in the latter of the latter | | | | | | | | ot, lactory, office | | - | City or Tow | n, State) | per or Hura i | Houte Number, |
| | spita nours neral | $\frac{3}{8}$ | 29a. Certifier 1 Certi | fying Ph | ysician: To the | best of my | knowledge, death | occurred at the | time, date | and place, a | and due to the | cause(s) and m | anner as st | ated |
| | n 24 h | Medical | (Check only 2 Medi | cai Exan | niner: On the b | asis of examers as a state of the state of t | mination and/or in | estigation, in my | opinion, de | eath occurre | ed at the time, | date and place, | and due to | the cause(s) |
| | Within com | Σ | 29b. Signature and title of cer | flier | PW | 182 | Q | 29c. Lice | nse number) 45 | 47 | -1 | 29d. Date signe | od (Month, I | Day, Year) 2009 |
| | | | 38. Name and address of persons. 38. Date filed (Month) Day, Ye | | completed caus | e of death | (Item 23a) (Type, i | Print) | M | sh | fron | Adve | Mrs | + HOSP |
| | Sta Registr | | MAR 11 | 200 | 9 Ben | www. | A. par | w | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Carlyle Phillips Month Emerson Year 930 4,2009 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbury Rehabilitation Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last of tholay) Wicomico 8. Date of Birth (Month, Day, Year) 05/28/1918 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Min 219-03-2154 90 **Director** Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d, Inside City Limits the Medical Examiner must be notified at Salisbury 1x∏Yes 2 □ No Directo Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t ō 21801 and 2 should be filed within 72 hours after death wi leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a o 300 Lemmon Hill Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 MYes 2 □ No If Yes, Give Army Year or DateArmy 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) pharmacist pharmacutical Injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Branche Holmes Phillips Beatrice Robertson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Liberty Rd., Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra John Phillips/step-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 3/10/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22 Holloway Funeral Home Professional Association Kerth R 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** can-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ ₩0 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an performed' 1 □ Yes 2 1100 funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death, investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death completely filled in by the ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

P.O. Box 68760 Division of Vital Records,

within 2 IVA

Registrar

DHMH 17 Rev 1/2001

Registrar's Signature

200 C IVIC

29c. License number

10

29b. Signature and title of certifier.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year 2033 M Shirley Ann Prince 12, 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Temple Hills 4013 23rd Parkway Prince Georges Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕱 F Months Days Hours Director 249-88-9418 3, 1947 61 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show event, the Medical Exprainer must be notified at Director 1 TxYes 2 □ No Temple Hills Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 20748 4013 23rd Parkway United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any hiury or other traumatic event, I'm I once. Paraprofessional DC Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Henry Kelly Martha Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4013 23rd Parkway
Temple Hills, Md. 20748

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Barnes/daughter 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 3/20/09 Clinton, MD. 22. Name and Address of Facility Hodges 21. Signature of Funeral Service Licenses & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** eroTic a Arteriosci disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Nknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performe certificate 2 1110 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☐ res 2☐ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Desidence} \) 6 \(\text{Other} \) (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in s 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1. Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar DHMH 17 Rev 1/2001

DX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year March John Luttrell Robson 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens Silver Spring 8. Date of Birth (Month, Day, Aug 11, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days ^Y 1917 West Virginia 1₩ 2□F 233-16-0554 91 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Prince George's Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3160 Gracefield Rd. 20904 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1942-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College Professor Higher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luttrell Robson Hattie Dale Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036 **Physician**

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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MD

Funeral

Director

within 72 hours after death with the Maryland

/Medical Examiner

burial-tran ed by the detached cate has , page 2 s

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: T 4 hours after death. Funeral Director: After this certificate ely filled in by the funeral director, pa

| _ |
|---|

| | James L. Patton/Guardian/Nephew 9200 Pl | | rel, MD 20708 | | | | | | | |
|---|---|---|--|---------------------------------------|--|--|--|--|--|--|
| | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremator | (Name of Di ry or other place) | ate 20c. Location - City or | r Town, State | | | | | | |
| | 4 Donation 5 Other (Specify) W. Arundel | Crematory 03/1 | 1/09 Odenton, N | ND . | | | | | | |
| | | | Service P.O. Box P.A. Clarksvill | | | | | | | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. | e mode of dying, such as cardiac or | r respiratory arrest, | Approximate Interval Between | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Card | Atherosclerotic Cardiovascular Disease Years | | | | | | | | |
| | Due to (or as a consequence of): | | | | | | | | | |
| ja | Sequentially list conditions, b. Due to (or as a consequence of): | | | | | | | | | |
| ä | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | |
| Exa | resulting in death) Last Due to (or as a consequence of): | C. Due to (or as a consequence of): | | | | | | | | |
| ical | d | | | | | | | | | |
| Med | IF FEMALE: | | | | | | | | | |
| Completed by Physician/Medical Examiner | 23b. Was decedent pregnant in the past 12 months? | pic pregnancy er (specify) | 23d. Date of de Month | 23d. Date of delivery Month Day Year | | | | | | |
| ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Oth | | month buy rour | | | | | | | |
| y Ph | Part II. Other significant conditions contributing to death but not resulting in the underly | 23e. Did tobacco use contribute t | e contribute to the cause of death? | | | | | | | |
| q pa | Cerebrovascular Accident, Dementia | robably 4 Hunknown | | | | | | | | |
| plet | | | 24a. Was an 24b. Were a | 4b. Were autopsy findings available | | | | | | |
| E O | | autopsy prior to performed? death? 1□ Yes 2□ No 1□ Yes | to completion of cause of h? ∕es 2 ☐ No | | | | | | | |
| Be (| 25. Was case referred to medical examiner? | 26. Place of Death | (Check only one) | | | | | | | |
| ြို | | DOA Other: 4 Nursing Hom | ne 5 ☐ Residence 6 ☐ Other (Spe | ecify) | | | | | | |
| ion: | 27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) Injury N | Work? | 28d. Describe how injury occurred | | | | | | | |
| ficat | 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, fired | 8f. Location (Street and Number or R | Location (Street and Number or Rural Route Number, | | | | | | | |
| Medical Certification: | 4 ☐ Homicide determined building, etc. (Specify) | City or Town, State) | | | | | | | | |
| ial O | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only 2 Medical Examiner: On the basis of examination and/or investign | urred at the time, date and place, a | and due to the cause(s) and manner a | s stated. | | | | | | |
| edic | one) and manner stated. | | ed at the time, date and place, and du | e to the cause(s) | | | | | | |
| Σ | 29b. Signature and title officerifier | 29c. License number | 29d. Date signed (Mon | | | | | | | |
| | | D24035 | March 9, 20 | March 9, 2009 | | | | | | |

Registrar

31. Date filed (Month, Day, Year)

MAR 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E.J. Machado, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, #7, TCHI, For State Registrar 03/09/2009, TLS Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day Year Robinson March atherine 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memorial Hospital Talbot 7. Age (Trays, last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕶 F Months Days Hours Min 214-32-0866 05 13 1932 Yrs. Director 05-13-1932 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Mocan Erri, the results in million any injury or other traumatic event, the "Mocan Erri, the results in million and the present in the control of the 1 ☐ Yes 2 No Director Md. 10e. Street and Number 10g. Citizen of What Country? 6724 21643 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robinson ဂ Albert Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridgeville, De. 19933 Date | 20c. Location - City or Town, State Country Dr. Dwayne O. Mapp, SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) Mary Pages 1 ment of F 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 103-11-09 Cambridge J.R. Brisco Mem. Park 22. Name and Address of Facility Bennic Smith Funeal Home 21 Sgnature of Fune S S Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximated the cause (Final Immediate Cause (Final Immediate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) terminol **Physician** Store /Medical Due to (or as a consequence of): Examiner RI Imaggy emi Cequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transi Due to (or as a consequence of): and Box 68760, physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ as been si 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate 1 ☐Yes 2 ☐ No of Vital 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 2160 Washington Steas SOM 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

| | | | For State | State of M | laryland | | artment of H | | nd Me | ntal Hyg | jiene, | 2009 | ngi | , 96 |
|--------------------------------|---|----------------------------|--|--|---|-----------------------|---|----------------------------------|--------------------------|-------------------------------|---------------------|-------------------------------|---|-----------|
| | | | Registrar 1. Decedent's Name (First, Middle, Las | | | Cei | rtificate of I | Death | 12 | . Date of Dea | eg. No. | 2003 | 3. Time of | Pooth |
| | Physicia | | Charlotte | • | Rupert | | | | | Month | Day 7 | | | P M |
| ā | /Medic Examin | | 4a. Facility Name (If not institution, give | | | | 4b. City, Town, or | Location of I | | arch | | 2009 County of Deal | 6:00 | |
| and the | | | Golden Living N | ursing Ho | me | | Frede | cick | | | | Frede | | |
| | Funeral | | Social Security Number 6. S | | ge (In yrs. las | | If Under 1 Year Months Days | If Under 24 | Hrs. 8. Min. | Date of Birth (Month, Day | Year) | 9. Bir | thplace (State o | r Foreign |
| | Director | | 220-44-7335 Usual Residence of Decedent | _ W 2 (A) | 93 | Yrs. | | | | ct. 6, | | | arÿland | |
| | land ow | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | | | 10d. Inside Cit | ty Limits |
| | Mary a-f sh | tor | Maryland Freder | ick | Wa | .1kers | willo | | | | | | 1 □Yes | 2 🔯 No |
| | th the | Director | 10e. Street and Number | ICK | , wa | IRCIS | 10f. Zip Code | | | 1 | 0g. Citiz | en of What Co | untry? | |
| | tth wii | ral | 8901 Crum Road | | | | 21 | 793 | | | Ur | nited S | tates | |
| | tems | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | ? | 13. | Vas Decedent of H f Yes, specify Cuba | ispanic Origir ın, Mexican, F | n? (Specif Puerto Ric | y Yes or No- an, etc.) | 1 | 4. Race - Ame Black, White | | |
| 36 | s afte | y F | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced | 1 ∐Yes 2 🔀 If Yes, Give Year or Dates: | No | | □Yes 2⊠No | | | | | Specify: | White | |
| 9 | thour stural | Completed by | 15. Decedent's Ed | ucation | | 16a. Dec <i>e</i> c | ient's Usual Occup | ation | | | 16b. Kin | d of Business/ | Industry | |
| 215 | hin 72 e. an "ng | ple | (Specify only highest gra- | de completed) College (1-4or t | | (Give | kind of work done o OO NOT use retired | durina most of | f working | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| 2 | d with | Son | ciomoniary, occorridary (o 12) | 5+ | | Н | omemaker | | | | | Own Ho | me | |
| nd | be file d oth event | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's | Name (F | First, Middle, I | Maiden S | Surname) | | |
| , | ould d Mer narke natic | မ | Roger Lease Klin | | | | | | | Alice | | | | |
| Ma | and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Event has routed by natified at | | 19a. Informant's Name/Relationship (7 | , | | | g Address (Street a | | | | | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventral methor natified at once. | | Barbara Bowers 20a. Method of Disposition | Cousin | | | Chestnut | | Road Date | | | rille, | | d |
| ÖE | ages ent of nt: If i | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | | sition (Name of natory or other place | | 1arch | 11, | | • | , | |
| 푩 | mit. F sartm sortar injur | | 21. Signature of Funeral Service Licent | | ML. | поре | Cemetery Name and Address | ss of Facility C | ZU Stauf | 09 for Fu | WOOD | lsboro, | Marylan | nd |
| m | Pa i i i | | Sharow Com | 1100 7 | MIN | 0 40 | Fulton A | Avenue | | | | | land 21 | 793 |
| | | / | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of | lications that caused | d the death. | Do not ente | er the mode of dyin | g, such as ca | | | | | Approximate Interval Bety | |
| Carried St. | Physician | Physician/Medical Examiner | Immediate Cause (Final disease or condition Chronic Obstructive lung den | | | | | | désaa | ase | | Onset and D | eath | |
| المرد | /Medical Examiner | | resulting in death) | Due to (or as | Chronic Electricative lung desease to (or as a consequence of): | | | | | | | | | |
| | | | Sequentially fist conditions | | | | | | | | | | | |
| | ted nsit | | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | a consequ e r | nce of): | | | | | | | | |
| | execu n and al-tra | | that initiated events resulting in death) Last | ed events 🔳 🕜 | | | quence of): | | | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | | | | | | | | | | | | | |
| 9 | rtifica ng ph as th | | IS SENANCE. | | | | | | | | | | | |
| Box | eath certific attending p for use as | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1 ☐ Live birth | | | Ectopic pregnancy | , | | | 2: | 3d. Date of del | | |
| 0 | the a | Sici | 1 □ Yes 2 ☑ No 9 □ Unknown | 4 ☐ Pregnant a 9 ☐ Unknown | at time of dea | | Other (specify) | | | | | Month | Day Y | 'e ar |
| σ. | that the de ned by the detached | | Part II. Other significant conditions co | intributing to death h | aut not resultis | na in the un | derlying cause give | n in Part I | - 7 | 23e Did tob | acco ne | e contribute to | the cause of de | aath? |
| Records, | w requires to be a should be a | Completed by | Hypertens | | | ng mano un | donying oddoo givo | ar ar r care is | | _ | s 2 | | | Inknown |
| S | w req | | | | | | | | - 4 | 24a. Was ar | | | | |
| | The lav | duic | | | | | | | - | autops perforn | ý I | prior to death? | topsy findings a completion of ca | use of |
| Vital | ician: The certificate ector, pag | a l | 25. Was case referred to medical | | | | · . | 26 Place of | Death (C | 1 ☐ Yes 2 | 2 [No] | 1 □Yes | 2 19 No | |
| > | S S I | 0 | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | ent 2 EF | NOutpatien | 3 □ DOA Othe | | | | | ☐Other (Spec | cify) | |
| 0 | ding Phys h. After this funeral dir | ü | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Inju | ury 28 y, Year) | Bb. Time of Injury | 28c. Injury Work | | | . Describe ho | | | | |
| Sio | tendi leath. tor: A | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | | M 1 🗆 Y | ′es 2□No | | | | | | |
| Division of | ul or Attending Physician: after death. Director: After this certification by the funeral director; | Certification: T | 4 Homicide determined | 28e. Place of Injubul | ury - At home c. <i>(Specify)</i> | e, farm, stre | et, factory, office | | 28f. | Location (Str City or Town | | Number or Ru | ral Route Numb | ner, |
| _ | spital ours a | င္တ | 29a. Certifier 1 Certifying Phy | sician: To the best | of my knowle | edge, death | occurred at the tim | ne date and r | nlace and | i due to the ca | auce(c) | and manner as | ctated | |
| | e Hos n 24 h e Fur | edical | (Check only 2 Medical Exam | iner: On the basis o and manner sta | ot examination | n and/or inv | estigation, in my or | pinion, death | occurred | at the time, da | ate and p | place, and due | to the cause(s) | |
| | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | ĭ ĕ | 29b. Signature and title of certifier | سرام | 10 | | 29c. License | number | _ | 25 | 9d. Date | signed (Month | , Day, Year) | |
| 3 | | | * | 1 | <i>'</i> | | 00054 | 636 | | 0 | 53// | 0/2009 | 7 | |
| | 12 | | 30. Name and address of person who c | 1-1 | leath (Item 23 | 3a) (Type, F | | \cap | | | 1 | 1, 00 | 1017 | 0.1 |
| | | | Mr. Syed W. Ha 31. Date filed (Month, Day, Year) | que /C | ar's Signature | ontd | laire | HVe. | , 11 | 'eael | ic | K, Me | 1,21/6 | 11 |
| | Stat Registra | - | TAR 122 | oz. negistra | ar s orgnature | 19 | " Parate | , | Ŧ | | | 1 | | |
| | | | | 1 | 67 | | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 19497 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2009 Eva Elizabeth Burroughs Raley March 11, 6:15 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 27960 Old Village Road Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Months Days Min 1 M 2 F Mary Tand 91 579-14-1779 10 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 X No St. Mary's Mechanicsville Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20659 27960 Old Village Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No White Specify: Specify. 3 Widowed 4X Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Middle Elementary/Secondary (0-12) College (1-4or 5+) Margaret Brent School School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha E. Hancock **Edward Burroughs** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Raley, Jr./Son 19151 Lake Drive, Valley Lee, MD 20692 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🗶 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/21/2009 Mechanicsville, Md All Faiths Ceme 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fungral Service Lic F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 MOOSI Clev 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 canl Due to (or as a consequence of): Sequentially list conditions, it may be a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 SNo 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 25-100 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

executed burial-tran P.O. Box 68760. attending physician for use as the buria Hospital or Attending Physician: The law requires that the death certificate be ned by the a s been signed by t should be detach Division of Vital Records, has certificate

Examine Physician/Medical \$ Completed Be

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show

r than "natural", or Items the Wedienl Examiner or

other

27 is marked of traumatic even

Item 27 other t

= 5 Department of Important: If any Injury or once.

Physician

/Medical

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Funeral

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Completed

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Maryland

the

death with

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, is 2 27. Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 162042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 2009.

Three Notch Rd. , Ste. 101 Md. 20659 Mechanicsville

State Registrar

31. Date filed (Month, Day, Year) NAR 16



| JNK | | Please Type or Print in Blace State of Maryland / For State | | Health an | | ygiene | Reg. No. 2 | nna nal. |
|--|----------------|---|--------------------------------------|------------------------------------|--|------------------------------------|---|---|
| Physicia | | Registrar 1. Decedent's Name (First, Middle,Last) | | | | 2. Date of De | ath | 3. Time of Death |
| cal Exami | | Oscar Alfredo | Reyes | | | February | Day Yea 21, 2009 | 0727 hrs |
| 1 | | 4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center | | tb. City, Town, or Cheverly | Location of Death | | 4c. County of Prince G | George's |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (| (In yrs. last birthday) 20 Yrs | If Under 1 Yea Months Day | | _ | 7/1988 | y 9. Birthplace (State or Ereign Salvador Ecountry) |
| ne Maryland or 28a-f show any fied at once. | | Usual Residence of Decedent 10a. State 10b. County Montgomery 1 MD Montgomery 1 | 0c. City, Town or Locati Rockvill | e | | | | 10d. Inside City Limits |
| ith the Maryland "3a or 28a-f sho | Director | 10e. Street and Number 5116 Russet Road | | 10f. Zip Code 208 5 | 53 | nat Country? Lvador | | |
| r death w or items must be | by Funeral | 3 Widowed 4 Divorced If Yes, Give Year or Dates: | X No | es, specify Cubar] Yes 2 No | spanic Origin? (Sp. Mexican, Puerto El Salva specify: tion (Give kind of v | Rican, etc.) adorei | Nhite Specify: | - American Indian, Black, e, etc. White |
| Pages 1 and 2 should be filed within 72 hours after pear of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or other tranmatic event, the Medical Examiner | Completed | 15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+ 2 Triangle Father's Name (First, Middle, Last) | during m | | e. DO NOT use reti | red) | Colle | ege |
| old be file Mental H marked o | Be | Jose Alfredo Reyes 19a. Informant's Name/Relationship (Type, Print) | 19b. Mailing | Address (Stree | Zoila | _ | | n, State, Zip Code) |
| nd 2 shou alth and 1 in 27 is r | | Zoila Reyes/Mother | | Russe | t Road | Rock | ville,Mo | d. 20853 - City or Town, State |
| permit Pages I at Department of Her Important: If ite | | XBurial 2 Cremation 3 Removal from State Dopation 5 Other Specify: 21. Signature of Funeral Service Ligenses | Gate of | ner place) Heave | n 3/ | 16/20 | o sil | ver Spring, NRVICE, P.A. pring, Md209 |
| hysician | | 23a Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. | | | | | | |
| /Medical xaminer | | Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence) | uence of): | | | | | Death |
| nted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence | | | | | | |
| ficate be execute g physician and the burial - trar | dical | UNPENDED AMENDED | | | | | | |
| ires that the death certificate by signed by the attending physical be detached for use as the but | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome 1 Live birth 4 Pregnant at ti 9 Unknown | 2 Fe | tal death 3 her (Specify) | Ectopic pregna | ancy | 23d. Date of Month | f delivery Day Year |
| es that the igned by t | ð | Part II. Other significant conditions contributing to death | but not resulting in the t | underlying cause | given in Part I. | | | ribute to the cause of death? Probably 4 Unknown |
| The law requires that has been page 2 should | Completed | 25. Was case referred to medical | | 26 Plac | e of Death (Check | per 1 ✓ Yes | topsy rformed? | Were autopsy findings availat prior to completion of cause o death? Yes 2 No |
| vican: hysician: this certif | Ö | evaminer? | t 2 🗸 ER/Outpatient | | Othor | ng Home 5 | Residence 6 | Other: |
| ending Physic ending Physic ath. or: After this or | tion: T | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Feb 21, 2009 | 28b. Time of 0256 hrs | | Jry at Work? Yes 2 ✔ No | | e how injury occur auto auto coll | |
| Hospital or Attendin 24 hours after death. Funeral Director: A | Certification: | Suicide 6 Could not be | or Road / Highway | • | actory, office building, etc. 28f. Location (Street and Nur or Town, State) E/B Rt. 50, Cheverly, MD | | | er or Rural Route Number, Ci |
| To the Hospital within 24 hours To the Funeral completely filled | Medical Ce | 29a. Certifier (Check only one) 2 Medical Examiner: On the best of my | knowledge, death occu | rred at the time, o | date and place, and | d due to the ca at the time, da | ause(s) and manne ite and place, and | r as stated. due to the cause(s) |
| To the To the Company | Med | and manner stated. 29b. Signature and title of certifier | | 29c. Licen | | | | ned (Month, Day, Year) |
| . I | | | | | | | | |

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. State
Registra AMEND#10 coerFH3/11/09, BWW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2009 **Physician** March 4, Jean Jacques Rondonnet 2:30 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7509 Spring Lake Drive #1 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 18, 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 579-58-5875 1**X** M 2□ F 71 Director 1937 France Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Director 1 X Yes 2 ☐ No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7509 Spring Lake Drive #1 20817 Funeral France 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify δ Specify: White 3 ☐ Widowed 4 ☐ Divorced unk "natural" Completed The Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) iene. • **than** " Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, 11st once. unk-12 unk Hair Salon Hair Stylist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk Raymonde Dugillot Lucien Rondonnet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) friend Victor Amram Obadia, 2192 Stratton Dr. Potomac, Md. 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Cremation 3 ☐ Removal from State 3-26-09 Falls Church, unk National Crem. 21. Signature of Funeral Service License MO0564 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Sonald (1007 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line death. Do not e mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Cardiac Arrest /Medical Due to (or as a consequence of) Examiner An ina Sequentially list conditions, if any, leading to immediate cause. Enter the original Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hyper Lipidemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: this certificate 1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the 29a. Certifier Medical (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number Lesu D0030191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jean-Pier‡e Faure, MD, 8218 Wisconsin Avenue, Suite P-9, Bethesda, MD 20814 31. Date filed (Manth. Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Ridings Antoinette 5:35 P [™] 3 /Medical 10 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard 10026 Maple Ave. ear If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1–27–1924 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1 □ M 2 🗷 F 216-16-0714 85 W.Va. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at "natural", or Items 23a or 28a-f sh edical Examiner must be notified 1 ☐ Yes 2 No Director MD Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10026 Maple Ave. 21046 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 ☐ Vidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Packaged Goods is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Mafale Rose Mafale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 separtment of Health an Important: If item 27 is Michael Ridings / Son 10026 Maple Ave., Columbia, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔲 Burial Ardent Cremation 3-11-2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. M01411 21. Signature of Fureral Service Licensee 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail use. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Small Cell Lung Cancer 6-7 Months /Medical Due to (or as a consequence of Examiner Metastatic Lung Cancer (liver, brain) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 **X**No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1∐ Yes 2 **X** No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061624 3/11/09 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Y Zhang 11065 Little Patuxent Pkway, Columbia, MD 21044

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) **KAR 12 2009**

parks

32. Registrar's Signature